THE EXPERIENCES OF FATHERS WHO FOUND CHILDBIRTH TRAUMATIC

Jody Etheridge

Supervised by:

Professor Pauline Slade

Dr Catrin Eames

30th June 2014

Submitted in partial fulfilment of the Doctorate in Clinical Psychology, University of Liverpool

Acknowledgements

There are many people to thank for help and support in the completion of this research project. My sincere gratitude goes to the fathers who were willing to give their time to take part in the study. It was a privilege to hear their stories. Also to Alex and Kath, whose story inspired the research.

Thanks to Professor Pauline Slade for her guidance and patience throughout the research process and Dr Catrin Eames for additional practical and moral support, particularly when recruitment problems seemed overwhelming! Also to Maureen Treadwell from the Birth Trauma Association for her support in getting the project going and her extensive efforts in facilitating recruitment of participants.

I am very grateful for the moral support and good humour of my DClin cohort in getting through this together; and to the rest of my friends who've encouraged me along the way. Finally, extra-special thanks to my family, who have always supported, encouraged and believed in me.

Table of contents

Total word count: 24892

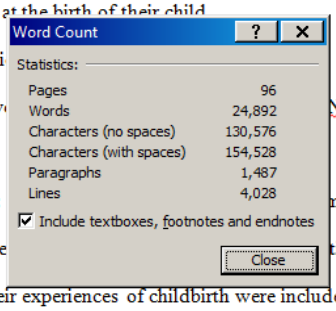
Abstract

Objective: To synthesise qualitative research reporting on the experiences of fathers who were present at the birth of their child.

Design: Systemati

Data sources: Fiv NFO, Scopus and Web of Science

Review methods: ns 'Father(s)', '(child)birth', 'qualitative' and 'e tive analysis of fathers' descriptions of their experiences of childbirth were included. Studies which focused only on medical interventions or specific surgical and home births were excluded; as were those in which the mother or child had died. A meta-ethnographic approach was used to analyse the included papers.



Introduction: Thesis Overview

This thesis takes as its focus the experiences of men who attend childbirth; presenting a meta-synthesis of literature on the experiences of fathers in routine delivery before moving on to an empirical paper researching the experiences of fathers who have experienced childbirth as traumatic.

Chapter One presents a meta-synthesis of empirical research into fathers' experiences of being present at the birth of their child. The trend for men's presence at childbirth and the early literature are discussed. A systematic literature search and meta-ethnographic approach to synthesis are described. The paper draws together common themes and metaphors from eleven qualitative studies into a synthesis regarding what fathers view as significant aspects of their experience at childbirth. The findings are discussed with regard to masculine ideologies, constructs of roles, self-efficacy and the role of maternity services in caring for fathers. Consideration is given to births which men may find difficult, which leads to Chapter Two.

Chapter Two is an empirical paper exploring the experiences of men who found the childbirth traumatic. A qualitative methodology was employed using semi-structured interviews and template analysis, drawing out aspects of men's experiences, coping strategies and the subsequent impact of trauma on their lives. The findings are discussed in terms of psychological constructs, particularly theories of stress and coping. The paper contributes to the existing literature through highlighting new findings as to how fathers experience and try to cope with a traumatic birth. Consideration is given to the clinical implications of the research and suggestions for further research are offered.

Both papers were prepared for publication: the literature review for the International Journal of Nursing Studies and the empirical paper for the Journal of Clinical Psychology in Medical Settings.

Chapter 1: Literature Review

Fathers' Experiences of Being Present at Childbirth:

A Meta-Synthesis

Manuscript prepared for submission to International Journal of Nursing Studies (see Appendix A for Author Guidance)

Abstract

Objective: To synthesise qualitative research reporting on the experiences of fathers who were present at the birth of their child.

Design: Systematic review and meta-synthesis.

Data sources: Five databases: CINAHL, Medline, PsycINFO, Scopus and Web of Science

Review methods: Databases were searched using the terms 'Father(s)', '(child)birth', 'qualitative' and 'experience*'. Papers containing qualitative analysis of fathers' descriptions of their experiences of childbirth were included. Studies which focused only on medical interventions or specific surgical and home births were excluded; as were those in which the mother or child had died. A meta-ethnographic approach was used to analyse the included papers.

Results: Eleven papers were included in the final synthesis. Eleven common themes were derived from the analysis. These were organised under four main concepts describing the experience of men attending childbirth: 'unknown territory', 'searching for a place', 'from agony to ecstasy' and 'being part of it'.

Conclusions: Fathers are positive towards being present at childbirth, although feel there is limited choice about attendance. They expect to be able to help and support their partner and desire direction about how to be involved. In the absence of this, they feel helpless and excluded. Fear, anxiety and helplessness, particularly in response to their partners' pain, are common emotions but these are recompensed by the joy of witnessing their child being born. Male-orientated antenatal preparation and increased communication and direction through labour and childbirth could potentially reduce the distress experienced.

Keywords: childbirth, father/s, meta-ethnography, meta-synthesis, qualitative

What is already known about the topic

- Men's attendance at childbirth can be beneficial for the man, woman and child but can be both a positive and distressing experience
- Men's roles during childbirth are often ill-defined, which may contribute to distress

What this paper adds

- Men's expectations about their roles during childbirth may contrast with the experience, which is challenging but ultimately joyful. When fathers are able to perform tasks and perceive themselves as useful, their experience is more positive.
- Ideas about acceptable masculine roles may inhibit men from showing their distress during childbirth.

Introduction

Men's attendance at childbirth has become commonplace in western cultures. In the United Kingdom, over 90% of men from married or cohabiting couples are present when their child is born (Kiernan & Smith, 2003; Singh & Newburn, 2000). Women generally report positive experiences of having their partner present to provide practical and emotional support (Somers-Smith, 1999). In a review of the empirical literature, Dellmann (2004) concluded that men's attendance at childbirth could be beneficial to themselves, their partners and their children; however, it could be both a distressing and a positive experience. He suggested that the role of fathers during childbirth was ill-defined and this lack of definition could contribute to the distress experienced.

Evidence suggests that continuous support for women during labour may reduce the likelihood of instrumental births and increase the mother's satisfaction with the experience (Hodnett, Gates, Hofmeyr & Sakala, 2013). The high rate of men attending for the duration of the childbirth means they are the most likely to fulfil this support

role. Therefore, understanding men's experience is important; not only in terms of recognising their capacity to offer support but also to consider the impact for the men themselves. A review of this area of research is relevant to clinical psychologists as men's experiences may highlight areas of emotional and psychological need for fathers in the birth situation, such as coping with potentially stressful birth events. There may also be implications for the development of fathers' attachments with their children dependent on their birth experiences.

Draper (1997) found that most research had focused on the roles men adopt during labour and had neglected the needs of fathers during pregnancy and birth. In the decade following Dellmann's (2004) review, research into the role and experiences of fathers during pregnancy, birth and early infancy has increased rapidly. Qualitative research has included studies investigating the experiences of fathers in response to particular childbirth events such as complicated deliveries (Lindberg & Engstrom, 2013), medical interventions (e.g., Williams & Umberson, 1999), and support from midwives (e.g., Aune, Dahlberg & Ingebrigtsen, 2012).

Three previous meta-syntheses of the research into fathers' experiences have been conducted. Two report on fathers' experiences of the transition to fatherhood and their role with the child (Chin, Hall & Daiches, 2011; Goodman, 2005). The third reports fathers' experiences in relation to maternity care during pregnancy, birth and the early postnatal period; concluding that fathers experience their role as undefined in response to maternity care, viewing themselves as "not-patient and not-visitor" in the process (Steen, Downe, Bamford & Edozian, 2012).

Aims

To the authors' knowledge, there has not yet been a synthesis of research into fathers' experiences of labour and childbirth. The aim of this paper was to synthesise

the findings of qualitative research into how fathers describe their experiences of being present at the birth of their child or children.

Method

Inclusion criteria

Research reporting fathers' experiences of being present at the birth of their child or children was included in the review. "Birth", for the purposes of this study, is defined as the labour and delivery of the child. Formal qualitative research (semi-structured interviews; structured interviews not subject to quantitative analysis) involving qualitative analysis, the process of which was described and reported in themes was included. Qualitative aspects of mixed-methods studies were included if they were more than a paragraph in length (if written) and had been subjected to qualitative analysis. Research involving both parents was included, provided that fathers' views were represented separately in the analysis. Only studies published in English were included in the review. Studies were included if they met quality criteria for at least six of the ten assessment indicators on the Qualitative Research Checklist developed by the Critical Skills Appraisal Programme (CASP, 2013; see Appendix B).

Exclusion criteria

Papers were excluded if they focused solely on fathers' experiences of particular health difficulties with either the child or mother, neonatal intensive care, or the death of their child. Home births and studies focused on one method of surgical delivery (e.g., emergency or planned caesarean sections) were also excluded on the basis that they may present a qualitatively different experience for fathers. Papers that focused on only one aspect of birth e.g., epidural, (Chapman, 2000) were excluded, as were those which focused only on support from health professionals, as these have been examined in a previous synthesis (Steen et al. 2012). No exclusions were made based on where the studies took place.

Search strategy

Given the variety of terms used to describe qualitative studies and the fact that titles do not always indicate the methods used (Ring, Ritchie, Mandava & Jepson, 2010), broad search terms were adopted. Five databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, PsychINFO, Scopus and Web of Science were searched using the terms "father/s" , "qualitative research", "qualitative methods" (for one database, all the variety of different qualitative methodologies were identified in subject headings), "experience*" AND "*birth". Medical Subject Headings (MeSH) terms and subject headings suggested by the individual databases were used to add to the search of key words. Full details of the search terms used are included in Appendix C.

Reference lists of relevant papers were scrutinised for additional studies, yielding one additional paper, Johnson (2002), which was included in the final analysis. One researcher was contacted via email regarding a pending publication but this could not be included as it was not yet in press.

Screening

Details of the processes of screening and selecting papers are illustrated in Figure 1. Following the removal of duplicate papers, titles were examined for relevance. This process produced 292 papers, the abstracts of which were read for relevance to the review question. Twenty-nine papers were read in full and 13 extracted for inclusion in the meta-synthesis. Following quality assessment two papers were removed, resulting in 11 papers for the final synthesis.

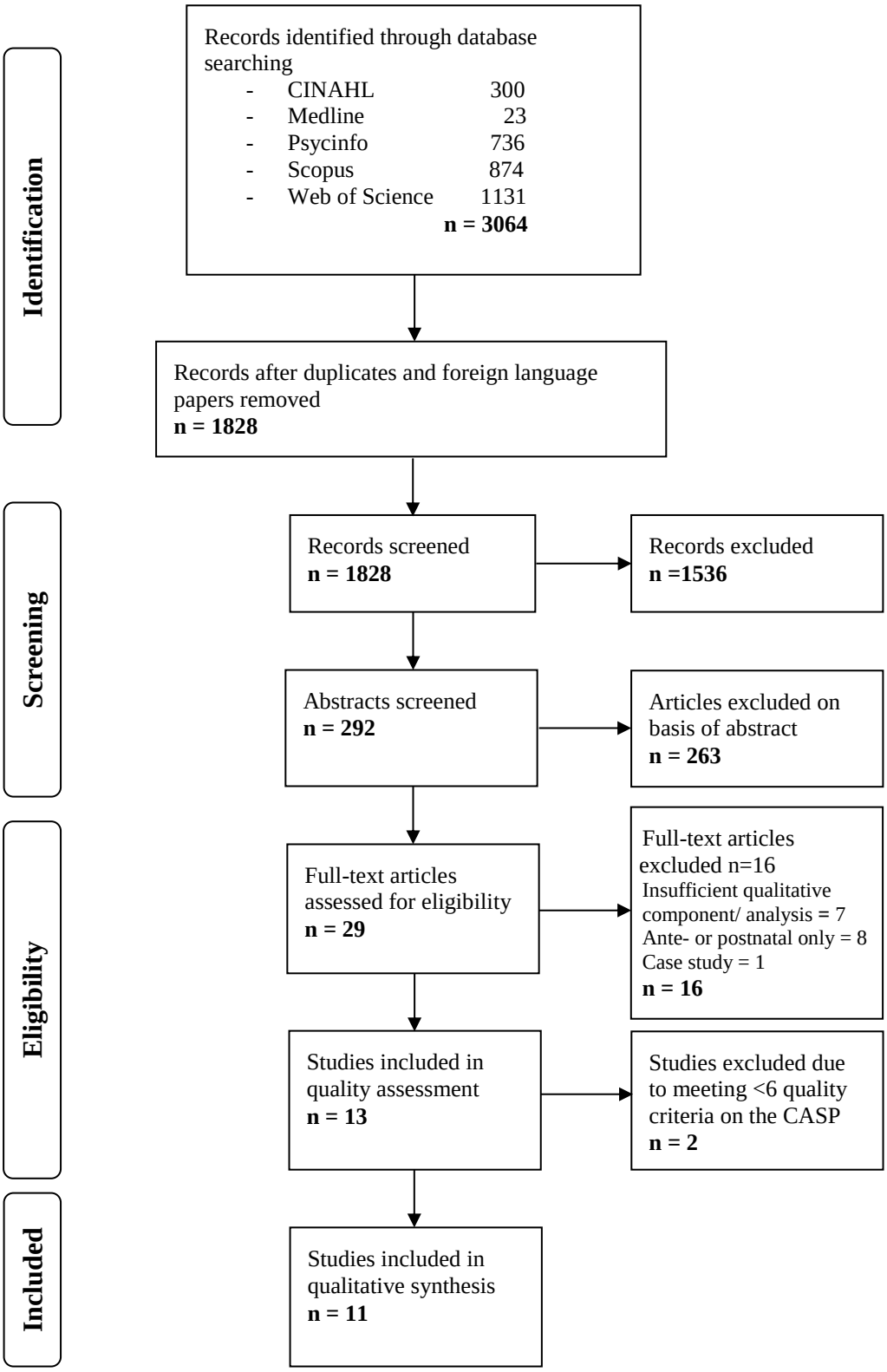


Figure 1 Screening and selection process (following Moher, Liberati, Tetzlaff & Altman, 2009)

Quality assessment

Quality assessment of qualitative research is an issue of debate with some authors arguing that it contradicts the epistemological basis of the research (Barnett-Page & Thomas, 2009; Spencer et al., 2003; Thomas & Harden, 2008). It is also an issue of contention as to whether the quality assessment tools that have been developed are suitable for the purpose (Dixon-Woods et al., 2007). Thomas and Harden (2008:48) argue, however, that some assessment of the quality of research is necessary to "avoid drawing unreliable conclusions". Given the debate in this area there is not an agreed process for assessing the quality of qualitative research and several tools have been developed (e.g. Spencer, Ritchie, Lewis & Jepson, 2003; Walsh & Downe, 2005).

To ensure the credibility of the review, quality assessment was undertaken using the CASP Qualitative Research Checklist. The CASP tool does not yield a score but assesses quality based on ten indicators: clarity of aims; appropriateness of qualitative methodology; design; recruitment strategy; data collection; consideration of the relationship between researcher and participants; ethical considerations; rigour of analysis; reporting of findings and value of the research.

Thirteen papers were assessed for quality (Table 1). Two studies were excluded at this stage. The first two items of the CASP are screening measures to assess whether there is further value in continuing with the paper. One paper (Sengane & Cur, 2009) was excluded at this stage. A second paper by Gabel (1982) was excluded as it failed to meet quality standards on six of the CASP indicators. The remaining papers were assessed, for the most part, to be good quality. The most common areas that authors failed to address was reflexivity.

Table 1 *Quality assessment of extracted papers using the CASP checklist*

Paper	CASP checklist item										Result
	Aim	**Method**	**Design**	**Recruitment**	**Data collection**	**Relationship**	**Ethics**	**Analysis**	**Findings**	**Value**	
Bäckström & Hertfeldt Wahn (2011)	✓	✓	✓	✓	✓	✖	✓	✓	✓	✓	Included
Chandler & Field (1997)	✓	✓	✖	✓	✓	✖	✓	✓	✓	✓	Included
Chin, Daiches & Hall (2011)	✓	✓	✓	Partial	✓	✖	✓	✓	✓	✓	Included
Dolan & Coe (2011)	✓	✓	✓	✓	✓	✖	✓	✓	✓	✓	Included
Erlandsson & Lindgren	✓	✓	✖	Partial	✓	✖	✓	✓	✓	✓	Included
Johnson (2002)	✓	✓	✓	✓	✓	✖	✖	✓	✓	✓	Included
Kululanga, Malata, Chirwa & Sundby (2012)	✓	✓	✖	✓	✓	✖	✓	✓	✓	✓	Included
Kunjappy-Clifton (2008)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Longworth & Kingdon (2011)	✓	✓	✓	✓	✓	✓	✓	Partial	✓	✓	Included
Premberg, Carlsson, Hellström & Berg (2011)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Included
Sapkota, Kobayashi & Takase (2012)	✓	✓	✓	✓	✓	✖	Partial	✓	✓	✓	Included
Gabel (1982)	✓	✓	✓	Unclear	Partial	✖	✖	✖	Partial	Unclear	Excluded
Sengane & Cur (2009)	✖	✓									Excluded

Meta-ethnography

Synthesis of qualitative research can take several forms (Barnett-Page & Thomas, 2009). The method adopted for this review follows the principles of meta-ethnography, as described by Noblit and Hare (1988). This method was chosen as it aims not only to aggregate themes and ideas found across studies, as in thematic synthesis, but also to generate higher order interpretations or theory that extends beyond the primary studies (Dixon-Woods, Agarwal, Jones, Young & Sutton, 2005). The process of meta-ethnography involves identifying the key themes and ideas from each study and comparing them across all of the other studies in the review. The relationships between these key themes are then analysed and interpreted to develop the synthesis.

Each paper was read several times and themes and ideas noted. These were then compared with the other papers for commonalities and differences. A list of key themes representing the main ideas across all the papers was developed and a grid was used to identify how each theme related to each of the studies (Table 4). The conclusions of the studies' authors were also noted as second-order interpretations. Finally, core concepts were developed from the first author's interpretation of the relationships between the themes.

Included studies

Eleven papers were included in the final analysis. Characteristics of these studies are shown in Table 2. In total, 133 men participated in the studies. The studies took place in five countries, the majority being in Sweden and the UK. All but one of the studies had taken place since 2008. Consideration was given as to the value of including the studies from Malawi and Nepal, in which health care systems and attitudes towards the presence of men during childbirth are significantly different from the other countries included in the review. These studies were included as they demonstrated similarities in the experiences and themes reported by the fathers,

suggesting that some aspects of the childbirth experience for men are not determined by how resourced the health care system is and that there might be some universal themes.

Table 2 *Characteristics of studies included in the final synthesis*

Authors and study site	Aims	Design	Participants	Analysis	Main findings
Bäckström & Hertfeldt Wahn (2011) *Sweden*	To explore how first time fathers describe requested and received support during a normal birth	Open-ended interviews within the first postpartum week	10 first-time fathers. Recruited via midwives within 24 hours of birth.	Qualitative content analysis	Over-arching theme of "being involved or being left out" Subcategories: - An allowing atmosphere - Balancing involvement - Being seen - Feeling left out
Chandler & Field (1997) *USA*	To describe first-time fathers' expectations and experiences of their partners' labours and deliveries and to examine the meaning of the experience attached to them	Initial interviews unstructured with responses used to develop semi-structured topic guide for subsequent interviews Interviews at 2 time points: end of third trimester and 4 weeks after birth	14 first-time fathers Recruited via newspaper adverts, snowball sampling and community contacts	"line by line" analysis and development of themes	Emergent themes: - "it's happening – it's beginning" - More work than the men had anticipated having to do - Increased fear - Hidden fears and emotions - Lack of inclusion - Increased excitement - Relief: "we made it" - Time to get acquainted
Chin, Daiches & Hall (2012) *UK*	To explore first-time fathers' experiences of becoming a father, focusing on their expectations and experiences and their views on how they are coping with this transition	Individual semi-structured interviews 4-11 weeks postpartum	9 first-time fathers. Recruited from NCT antenatal classes	Interpretative Phenomenological Analysis	Superordinate theme "searching for a place" Sub-themes: - The separation connection struggle - A sense of utility, agency and control - Changing focus of affection
Dolan & Coe (2011) *UK*	To explore how men construct masculine identities within the context of pregnancy and childbirth and also how healthcare professionals construct masculinity.	Individual semi-structured interviews at two time points: 4- 8 weeks ante- and post-natal	5 first-time fathers & 5 healthcare professionals. Fathers recruited via face-to-face contact during antenatal appointments	Coding and thematic analysis; fathers' and professionals' interviews analysed separately	"Being there" – men's experiences of labour and birth.[1] Men adopted 'instrumental/ active roles' and required direction. They did not express their worries or concerns. "Being there" was important to all the men

1. Themes relevant to men's experiences of birth extracted from wider analysis

Erlandsson & Lindgren (2009) *Sweden*	To describe fathers' experiences at the birth of their child from the father's perspective	Individual open-ended interviews 8 days to 6 weeks postpartum	16 fathers identified by 6 midwives from two district maternity clinics	Phenomenological approach	Essential meaning of childbirth: "From belonging to belonging through a blessed moment of love for a child" Constituents: - Changing perspective of life - Being in a relationship - Living through a life change
Johnson (2002) *UK*	To explore men's experience of childbirth	Individual semi-structured interviews following the format of the Pregnancy Outcome Questionnaire, within one week of birth	20 fathers who volunteered from a larger survey study of 53 men. Recruited from 3 GP surgeries.	Thematic phenomenological analysis	- Being at the birth was a positive experience but included feelings of helplessness at partners' pain - Men thought their role was primarily to support the partner - Most men felt pressure to attend - Men were not prepared for the experience
Kululanga et al. (2012) *Malawi*	To explore the views and experiences of men who had attended the birth of their children	Semi-structured interview	20 indigenous Malawian men. Recruited from health centres during postnatal checks and through snowballing technique	Content analysis	- Motivation to attend birth was influenced by midwives, peers and partners - Positive experiences: gaining knowledge about birth, advocating for partner, witnessing the child being born. - Men experienced feelings of shame, helplessness, feeling unprepared, tension with the health worker and exclusion from decision-making - Period of reflection and resolution on the experience after birth

1. Themes relevant to men's experiences of birth extracted from wider analysis

Kunjappy-Clifton (2008) *UK*	To explore the role of first-time fathers during the birth process and to explore the meaning of this experience for these men	Semi-structured interviews between 10 – 21 days postpartum	6 first-time fathers Recruited from one birth centre using convenience sample method	Phenomenological thematic analysis	2 themes relevant to the birth experience [1]: - "Hard labour" – helplessness at inability to support, isolation, pain of partner and lack of knowledge. - "The experience of birth" – positive impact. Most were glad to have attended and thought it important, although some felt pressured.
Longworth & Kingdon (2011) *UK*	To explore the role, expectations and meanings that individual fathers ascribe to their presence at birth	Semi-structured interviews at two time points: antenatally and postnatally	11 expectant fathers	Independent interpretive summaries, leading to 4 main themes through collaborative discussion	4 main themes: - Fathers' disconnection with pregnancy and labour - Fathers on the periphery of events during labour - Control - Fatherhood beginning at birth and reconnection
Premberg et al. (2011) *Sweden*	To describe fathers' experiences during childbirth	Open-ended "re-enactment" interviews conducted 4-6 weeks postpartum	10 fathers Purposively selected by senior midwife from two labour wards	Phenomenological life-world approach	Essential meaning "An interwoven process pendulating between euphoria and agony". 4 constituents: - A process into the unknown - A mutually shared experience - To guard and support the woman - In an exposed position with hidden strong emotions
Sapkota et al. (2012) *Nepal*	To explore husbands' experiences of supporting their wives during childbirth.	In-depth, semi-structured interviews	12 first-time fathers recruited from a delivery centre caring for women experiencing normal pregnancies	Thematic analysis	6 themes identified: - Being positive towards attendance - Hesitation due to embarrassment - Fear, helplessness and frustration - Being able to support - The need to be mentally prepared - Enlightenment

1. Themes relevant to men's experiences of birth extracted from wider analysis

Results

Eleven themes were derived as representative of the common ideas found across the studies. Table 4 illustrates how each paper was represented in these themes, following the example of Britten et al. (2002). Where cells are left blank, there was no evidence of the theme in the study. Notes written in parentheses indicate studies in which contradictory themes were found. Four core concepts – representing the first author's interpretation of the key aspects of fathers' experiences – are reported. The themes that contribute to each concept are identified (see Table 3).

Table 3 *Process from themes to concepts*

Themes – initial analysis	**Themes – final analysis**	**Core concept**
Role uncertainty Desire for direction	1.1 Role uncertainty	1. Unknown territory
Lack of knowledge	1.2 Knowledge and preparedness	
A labouring couple	2.1 In it together	2. 'Searching for a place'
To support and advocate	2.2 To support and advocate	
Communication	2.3 Information and communication	
Exclusion	2.4 Exclusion	
Fear and anxiety	3.1 Fear and anxiety	3. From agony to ecstasy
Helplessness	3.2 Helplessness	
Hidden emotion	3.3 Hidden emotion	
Joy at birth	3.4 Joy and relief	
Importance of being present	4. Being part of it	4. Being part of it

Table 4 *Common themes and metaphors across the studies*

Themes	Bäckström & Hertfeldt Wahn (2011)	Chandler & Field (1997)	Chin, Daiches & Hall (2012)	Dolan & Coe (2011)	Erlandsson & Lindgren (2009)	Johnson (2002)
Role uncertainty	Fathers sometimes didn't know how to help their partners	Some men expressed a wish for health professionals to show them how to help, rather than take over	Some men reported feeling like a "spare part" although they wanted to be involved	Men weren't proactive; they relied on partners and midwives for direction	Men described feeling confused and uncertain in the absence of instruction from staff.	Many men felt ineffective during labour and some wondered why they were present at all
Knowledge & preparedness	Fathers had prepared through reading and talking to others	Men found that labour was harder than expected and that they had to work harder	Some men struggled to adjust to being a "spare part" because they hadn't expected this role.			Men reported being "shocked" by partners' pain and unprepared for the experience
In it together	Fathers wanted to be involved so they could have a good connection with their partner during labour	Men wanted to support their partners but also be a partner in labour and witness the birth	Men wanted to be involved, although sometimes felt like a spare part	"Being there" from start to finish was important to the men.		Some men wanted to be involved, others felt they were expected to be there and didn't have a real choice.
To support & advocate	Fathers took direction from or imitated the actions of the midwives to support their partners	Men wanted to support their partners		Men provided physical support as directed by their partners and the midwives		Most men believed their role was to offer support
Information & communication	Men wanted midwives to explain what was happening and why	Men found procedures weren't explained adequately to them by health professionals		One man perceived health staff as providing inadequate guidance to his partner		Men felt helpless and confused in the face of mixed messages from midwives
Helplessness	If fathers did not know how to help their partners, they experienced a sense of helplessness and panic. Unresponsiveness from midwives could also induce feelings of helplessness	Helplessness at pain of the woman and the man's perception of his support as being ineffective		Men lacked confidence in their abilities to help their partners during labour		Seeing their partner in pain and unable to do anything made the men feel helpless and powerless.

Exclusion	Limited interaction by the midwife or failure to listen to the couple resulted in fathers feeling left out	"men felt their presence was tolerated rather than being a necessary part of the labour & birth"	Communication and invitations by staff to participate influenced feelings of involvement			Being invited to cut the umbilical cord brought the men in from the periphery and was the one time they felt useful
Fear & anxiety		Increasing fear and anxiety as labour progressed		Men described worry, anxiety and fear	Men experienced fear and sometimes doubt about staff's ability to control the situation	
Hidden emotion		Men tried to hide their distress so that they would not distress their partners		Men tried to maintain a calm façade in order to keep their partner calm	Men tried to deal with their own emotions and stay in control	
Joy at birth		Fathers experienced feelings of joy, elation and euphoria at the birth.	Birth was an emotional event for fathers	Being present to experience the emotion of a child being born	Men described the experience as incomparable to other life events and a great experience	Reaction to the birth was emotional and generally positive (although some men reported tedium)
Being part of it				"Being there" from start to finish was important to the men	The experience of birth "was characterised by belonging"	Men felt it was expected that they would be present
Second order interpretation	Fathers wanted to be involved in labour. Midwife practices either enabled or prevented this.	Men wanted to be present at birth but found the experience difficult through anxiety about their role and feelings of helplessness.	"inconsistency in fathers' experiences of involvement in the labour process… Fathers given minimal explanations may feel physically detached an occupy a passive role. In addition this may add to their anxiety about the welfare of their partner and child."	"men tended to concede power and control, which assigned them to marginalised positions. At the same time, men's practice was also informed by core masculine standards, particularly the notion of men as stoical and self-reliant in the face of adversity"	"The moment of birth was a life changing and overwhelming moment characterised by feelings of love and belonging"	"the male partner may have a largely unformed expectation of what he is about to take part in, with little knowledge of its potential physical, psychological or emotional realities"

Themes	Kululanga et al. (2012)	Kunjappy-Clifton (2008)	Longworth & Kingdon (2011)	Premberg et al. (2011)	Sapkota et al. (2012)
Role uncertainty	Men were frustrated because they did not know how to help	Most men felt they were unable to offer meaningful or practical support and wanted more direction	Men seemed unsure about their role and how to involve themselves more	(Men described performing a range of practical roles during childbirth)	
Knowledge & preparedness	Limited preparation and antenatal classes did not prepare them adequately.	Men lacked a clear idea of the process of childbirth (although they had tried to prepare)	Parentcraft classes didn't prepare men for their role at birth		Men wanted more antenatal preparation about how to help
In it together				'Childbirth is experienced as a shared matter for the couple. The man experiences himself and the woman as a team.'	
To support & advocate	Men acted as advocates for their partners in addition to providing psychological support	Men offered physical and emotional support as well as advocating for her needs and wishes to staff		Men provided physical and emotional support and thought their role was to liaise on partners' behalf	Husbands were under-confident in offering physical support but acted as a liaison between wife and midwife
Information & communication	Neither the men nor their partners were involved in decisions about obstetric care	Some men felt ignored during the process and wanted more communication with midwives	Level of communication heavily influenced fathers' feelings of control & their perceptions of the birth	Men tried to glean information from body language and found unclear information distressing	
Helplessness	Men did not know how to respond to their partners' pain and felt useless as a result	Lack of knowledge about the process, feelings of isolation and seeing the partner in pain led to feeling helpless		Seeing their partner in pain and being unable to help resulted in the men feeling helpless	Men did not know how to help their wives cope with the pains of labour
Exclusion	(Most men were not concerned that they were not involved in decisions) but some wanted to be consulted	Men felt that they were not part of the process and that they could offer no practical help	Fathers could find themselves on the periphery of events; (communication from staff increased sense of involvement)	"clinical routines sometimes prevent them from participating" in birth and men can feel overlooked	

Fear & anxiety	Fearful at the sight of their partner losing blood and her pain difficult to witness			Anxiety and distress at seeing their partners in pain	Fear for the outcome of the delivery and distressed by their wives' pain
Hidden emotions	Most men pretended to be strong for the sake of their partners, although they felt afraid.			Men hid their own feelings in order to avoid upsetting or worrying their partner	Despite feeling worried themselves, men tried to help their wives not to worry.
Joy at birth	Fathers described joy at their child's arrival and relief at the ending of pain for their partners	Fathers described a fantastic and magical experience	Whatever the birth experiences, all fathers expressed joy at the arrival of their child	Men were emotional and experienced joy at the child's birth, as well as relief for their partners	
Being part of it		Men were generally pleased to have attended, even if they had done so under pressure		Shared experience of childbirth is overwhelming	
Second order interpretation	"men's preparation for attendance at labour and childbirth is a critical factor for a positive experience."	"despite feeling exhilarated by being present at the birth of their child, men largely reported feeling helpless and being marginalised by the process."	"birth is the moment that fathers ascribed as the beginning of fatherhood. However, through their lack of knowledge and perceived control, they struggle to find a role there"	"The essential meaning of first-time fathers' experiences of childbirth is: an interwoven process pendulating between euphoria and agony"	"Nepalese husbands tend to experience over-whelming emotional feelings in the labour or delivery room if they are allowed to attend the birth without prior preparation."

Core concepts and component themes

1. Unknown territory.

This concept describes the experience that, having decided to be present at childbirth and anticipating that they would have a useful role, it was not always easy for fathers to know what their function was. It was developed from two component themes: role uncertainty; and knowledge and preparedness.

1.1 Role uncertainty.

Fathers across several of the studies expressed a sense of uncertainty and under-confidence about their function in the birthing room. Although they had anticipated that the focus would be on the woman and child, they had often expected that they would be able to perform a more involved role. With this uncertainty came a desire to be directed by the woman and health professionals as to what to do. In the absence of this direction, men felt redundant and confused.

> *No one gave me instructions exactly where to be…I felt confused. It was a bit like I was walking round in a fog, not knowing where to go. (Erlandsson & Lindgren, 2009)*
>
> *I would like to have a more active role, preferred to be directed as I did not [know] [sic] what to expect (Kunjappy-Clifton, 2008)*

However, Premberg et al. (2011) found that fathers reported that they were involved when instructed and given tasks by the midwife.

1.2 Knowledge and preparedness.

This theme linked with the idea of role uncertainty as, in many cases, there was a marked difference between men's expectations of the birth and the experience itself, which may have contributed to their confusion about how to act. Men described shock of the intensity of the pain of their partners; the process and difficulty of labour and the

inability to offer as much help as they had anticipated. These unforeseen aspects often led to anxiety and fear.

> *I didn't know that women bleed so much when they are giving birth. My partner bled so much and I was scared that I was going to lose her. (Kululanga et al., 2012)*

Some also reported that antenatal information had not adequately prepared them for the experience of being present and that, had it done so, they could have been more useful to their partners.

> *I know at the classes the midwife bangs on about stuff, but it's not like a bloke explaining what it was like for them, and when they do say, what they say is often the crap they are supposed to, rather than the reality. (Johnson, 2002)*

2. 'Searching for a place'.

The title of this second concept is taken directly from Chin, Daiches and Hall (2012) as it seemed to encapsulate ideas that ran throughout the studies. The descriptions that the men gave of their experiences indicated that, throughout labour and birth, they experienced fluctuating levels of involvement. At times, this was mediated by their own actions, whilst at others the practices of health professionals determined how included the fathers felt. Men seemed to begin the process with a sense of being in it together with their partners and having a role to support her and advocate on her behalf. However, dependent on the information they were given and communication they had with the woman and health professionals, fathers' experiences changed. They could feel excluded from events and experience themselves as redundant.

2.1 In it together.

Fathers generally saw themselves as an important part of the birthing couple, even in countries in which the practice of men's attendance is less well-established. Fathers in these studies usually wanted to be present for the birth and saw themselves as part of a team with their partners. Dolan & Coe (2011) describe the fathers' sense of "being there" as the most important aspect for them.

> *We were in this together, and we had to see it through…What other way could be more beautiful…than doing it together? (Chandler & Field, 1997)*

Although most fathers expressed their intention to be part of the birth, Johnson (2002) and Kunjappy-Clifton (2008) note that men had not always chosen to be present and were sometimes there at the behest of someone else.

> *To be honest, I was not sure whether I really wanted to be there, but L.., well, she sort of assumed, and then I felt I had to be there, otherwise I'd be letting her down. (Johnson, 2002)*

2.2 To support and advocate.

Men reported that their role during labour was to support their partner physically and emotionally, whilst also acting as an advocate for her with staff. They described completing practical tasks, such as massage, and cooling her down, as well as offering motivation and strength. When men were able to fulfil these roles, they experienced less anxiety, fear and frustration.

> *I dabbed her face with a wet towel. And got told off for wetting her fringe [laughs]. But I was there by her to be fair…Doing what she wanted…And taking instructions off the nurses as well… (Dolan & Coe, 2011)*

2.3 Information and communication.

Where men experienced good levels of information and communication they felt less anxious and more involved in the process; conversely, when communication was lacking their worries increased and they felt excluded.

> *I don't know how long it was…I started sort of standing outside the corridor of the cupboard waiting for someone to pass to sort of grab and ask what was going on… (Longworth & Kingdon, 2011)*

The theme of communication also links with the concept of men's understandings and expectations of their roles during childbirth. Several studies commented that men were passive and wanted direction about what to do, rather than using their initiative in the labour process. The style of communication was important; men felt more at ease when they perceived staff to take their questions seriously and give trustworthy answers, rather than those which they thought were given to make them feel better (Bäckström & Hertfeldt Wahn, 2011).

2.4 Exclusion.

In contrast to experiencing a sense of involvement when they were able to perform practical tasks or were informed as to how to help, men described at times feeling excluded.

> *I felt like an absolute spare part in all of that that went on there was nothing I could do, nothing physically…which is really weird because you want to get involved (Chin, Daiches & Hall, 2011)*
>
> *When you get in there, you are not really part of the process…You were very much left on your own device. (Kunjappy-Clifton, 2008)*
>
> *To be honest, I felt like the spare one at a wedding; I felt useless and clumsy. (Johnson, 2002)*

Exclusion was not always framed in negative terms. Dolan and Coe (2011) reported that men did not appear to be concerned by their marginal roles in the labour room. They expected to be seen as less important than their partner and infant but did expect some level of inclusion (Premberg et al., 2011). Men seemed to feel most included when they were able to perform practical tasks. They felt excluded when staff ignored their intimate knowledge of their partner and her needs (Kunjappy-Clifton, 2008).

3. From agony to ecstasy.

The fathers described myriad emotions; distressing and joyful. The emotional experience of being at the birth was one of extremes: from anxiety and fear, which they hid from their partners, through helplessness at the partners' pain, to joy and relief when the labour was over and the child was born.

3.1 Anxiety and fear.

The most common emotions described by the fathers were anxiety and fear. This was usually described in terms of how they felt about their partners' experiences and also the outcome of the labour. Witnessing the partner in pain was a highly distressing experience for the men and featured prominently in their descriptions:

> *I was pretty anxious…pretty worried too because she was in a lot of pain (Chandler & Field, 1997);*
>
> *it really hurt to see her in so much pain…it hurt my soul, so much so that I started to cry (Premberg et al., 2011).*

At times fear resulted from lack of understanding about what was happening:

> *You're worried, you're anxious, you're scared. You don't know what's going on. (Dolan & Coe, 2011);*

whilst some men expressed concern about the competence of health care professionals:

I was afraid. In my head I'm thinking this will not do. (Erlandsson & Lindgren, 2009).

3.2 Helplessness.

This theme featured strongly with the majority of studies reporting the expectant fathers' sense of helplessness during the labour and birth process. This was often related to the difficulty of witnessing their partners in pain but being unable to offer any practical help or relief. For some men it came as a shock that labour was such a difficult experience:

…the labour…they didn't tell me about that…it was a shock for me this experience that she was in so much pain and there was nothing I could do, except be by her side…(Premberg et al., 2011)

To tell you the truth, I felt so helpless just watching (Sapkota et al., 2012)

In several of the studies, it appeared that the men had expected that they would be able to help their wives more than they found to be possible in the actual event, which led to feelings of helplessness, inadequacy and frustration. As mentioned previously, lack of knowledge about the process of childbirth contributed to this theme.

3.3 Hidden emotions.

In spite of the anxiety and fear described by the men almost all of the studies reported that they tried to hide their true emotions from their labouring partner.

I kept her calm…I couldn't show I was worried (Dolan & Coe, 2011)

I was telling her not to worry but I myself was worried deep down (Sapkota et al, 2012).

To see the person you love and who's having your baby in such pain, it wasn't a pleasant experience…so I turned away and looked out the

window so she wouldn't see me being sad, it wouldn't have helped her. (Premberg et al.,2011)

The men seemed to feel responsible for keeping their partner calm and did this through trying to mask their own difficult emotions. Interestingly, one partner who was offered support from midwives found it helpful but reported that he was somewhat uncomfortable with the experience as *"I am used to being a man"* (Premberg et al., 2011: 850).

3.4 Joy and relief.

Almost all of the studies found that fathers reported that, in spite of many difficult and distressing emotions they may have experienced through the labour, being present for the birth of their child was a joyful and overwhelmingly positive experience. This emotion was often coupled with relief that their partner's pain had ended.

The most wonderful thing I have been through my whole life but also the most dreadful to see her suffer the way she did. (Premberg et al., 2011)

I was overwhelmed with joy to see our new born baby. It was amazing that at the same time all the pain my partner was experiencing ceased. (Kululanga et al., 2012)

Although this was the majority view, there were contrasting experiences in which men reported boredom at the process (Johnson, 2002).

4. Being part of it.

This concept was something that seemed difficult to quantify for the men but indicated that the act of being present for birth, whatever the experience, was important. Participants described "being there" (Dolan & Coe, 2011) as the critical issue and that

"Being there sends out the right message" (Johnson, 2002). The moment of birth signalled an overwhelming change in life for the men (Premberg et al., 2011).

Synthesis

Men's experience of childbirth is one of extremes and contrasts. Labour and childbirth is experienced as a challenging environment in which they seek to negotiate their place as part of the parent team; however, their expectations frequently contrast with the reality and they often feel underprepared. Fathers fluctuate between being present, offering practical and emotional support to the woman and being very involved, to experiences of being excluded from the process and uncertain how to act. The range of emotions experienced reflects the level of involvement and usefulness they feel. There are tensions between the challenges of the experience and traditional concepts of masculine roles such as avoidance of femininity, restricted emotions, self-reliance, status and 'toughness' (Levant et al., 1992). Men attempt to assist their partners through hiding their own difficult emotions and presenting a calm façade. These difficulties are usually recompensed by joy, relief and overwhelming positive emotion at the safe delivery of their child.

Discussion

The aim of this review was to synthesise qualitative research on fathers' experiences of being present at childbirth. The findings suggest that it is a complex experience for men and that their expectations may contrast sharply with the lived experience. Expectant fathers seem to experience labour and delivery as unknown territory in which they find it hard to establish a role and experience distressing emotions, at times seeming out of depth. This echoes the findings of previous reviews (Dellmann, 2004). However, in addition to the more stressful aspects of being present, when they are included and involved men feel positive towards the experience;

ultimately experiencing the joy of their child's birth and feeling it important to be part of that process.

Constructs of masculinity and gender roles seemed to influence much of the men's experiences during labour and birth. Kaufman (1994: 65) argues that traditional constructions of masculinity emphasise heavily the notion of power but that this comes at a cost to men:

> *"We have to perform and stay in control. We're supposed to conquer, be on top of things, and call the shots. We have to tough it out, provide and achieve. Meanwhile, we learn to beat back our feelings, hide our emotions, and suppress our needs".*

There is a clear tension between what is 'expected' of men and what they face as part of the childbearing couple in terms of the labour and childbirth process. The 'unknown territory' of labour, bringing with it uncertainties about what is happening and how to act, conflicts with the notion that the man must be in control, echoing the findings of Steen et al. (2012) that fathers find themselves "not-patient and not-visitor" in maternity care. This 'gender role strain' (Pleck, 1995) may contribute to some of the distress experienced by men during labour.

The men's attempts to hide their strong, difficult emotions during labour and birth are also consistent with traditional masculine gender roles (Kaufman, 1994). Through attendance at childbirth, men may be being exposed to positions that demand they violate traditional gender roles, whilst simultaneously taking on a new role of 'father', which brings its own expectations (e.g., Chin, Hall & Daiches, 2011). However, as the trend for men's attendance at birth has increased, this seems to have been incorporated – at least in western cultures – into constructs of fatherhood, hence the importance of "being part of it". Dolan and Coe (2011) found that men did successfully construct

masculine identities through childbirth and the finding that most men would choose to be present at a birth again (e.g., Sapkota et al, 2012) suggests that the experience has many positive aspects.

Concepts of self-efficacy (Bandura, 1997) may also be important in considering men's childbirth experiences and their search for a place within it. Men anticipated they would be part of the "labouring couple" (Draper, 1997) and that they would be able to enact the role of supporter and advocate. Men felt more relaxed and less anxious when staff communicated with them and when they were included through being able to perform practical tasks and carry out their anticipated roles. This is consistent with findings that men tend to adopt practical approaches to coping (e.g., Matud, 1994). This suggests that the extent to which men are able to exert a sense of control may influence their experiences of birth. Research with women indicates that greater levels of perceived control during birth influences both satisfaction with the experience and post-natal adjustment (Stevens, Wallston & Hamilton, 2011).

Limitations

Although care was taken to provide a balanced synthesis of the research, the review has some limitations. The papers ranged in quality and rigour of methodology and analysis, with some providing relatively few participant quotations to support the assertions made. In addition, the number of participants within each study was small and the review overall represents findings from just 133 men. Differences in the epistemological stances of the researchers may also have led to certain information in the studies being privileged over others, which would not have been seen in the synthesis.

The review was conducted by one researcher, which can be problematic from the point of bias in the analysis. The second and third authors read the analysis drawn

from the themes and second-order interpretations highlighted in the literature review but were not involved in the analytical process. This is clearly a limitation of the review and the trustworthiness of the analysis would have been strengthened through the inclusion of multiple researchers in the process. The CASP tool was used as a means of assessing the quality of the individual papers; however, the analysis could have been made more robust through additional checks, such as contacting the authors of the original papers to assess the integrity of their findings. Some researchers may disagree with the use of quality appraisal to exclude papers in the synthesis, as explained previously.

Clinical implications and further research

Several studies highlighted the need for better preparation (Johnson, 2002; Kunjappy-Clifton, 2008; Sapkota et al., 2012), which has been shown in previous research (Deave & Johnson, 2008). Men thought they would benefit from individual, father-focused antenatal classes to address their particular needs and think about the tasks that they could perform during labour (Kunjappy-Clifton, 2008). In recent years, companies delivering these classes have been established (e.g., Daddynatal) although as yet there is no research as to their effectiveness. Greenhalgh, Slade and Spiby (2000) found that attendance at antenatal classes did not always have a positive impact on men's birth experiences and could actually be detrimental, especially for those who tend to avoid threat information. However, there is tentative evidence that antenatal preparation may reduce distress in fathers who are afraid of childbirth (Bergström, Rudman, Waldenström & Kieler, 2013). This may indicate the effect of a different focus of antenatal preparation which attends more to the father; although this needs further exploration.

During childbirth, fathers could be supported through increased direction and information about what they can do in the situation. Men desired to be informed

throughout the process of labour, and where this was done successfully, their experience was less distressing (Bäckström & Hertfeldt Wahn, 2011). Further research into how men's roles during child birth can be clearly defined and communicated to them is required. Support for both mother and father is important. Aune et al. (2012) found that having an identified student midwife present throughout antenatal preparation and birth led to mothers and fathers feeling more reassured and supported through the process.

As men's attendance at childbirth is so commonplace, further study of the impact of this practice would be useful. Research could consider the long-term impact on men's relationships and attachments with their children or partner as a result of being present at birth. In addition, any potential negative consequences on fathers, or families, could be investigated further to identify circumstances in which it may not be beneficial for fathers to be present at birth.

The studies included in this synthesis were of men who attended routine, uncomplicated births. In the event that a healthy mother and child is the outcome of the experience, it seems that the difficult experience of being present during labour and birth may be over-ridden or recompensed. Where the question of men's attendance at birth may become more important is when the outcome is not the joyful conclusion to a difficult experience but one in which complications arise. In such circumstances, the joyful resolution would not be gained and the negative emotions and experiences could potentially become overwhelming for the father. White (2007) found that some men reported trauma symptoms following childbirth experiences years earlier; however, it should be noted that there are a number of methodological limitations with this study, including lack of objective measures of symptoms.

Conclusion

Attending childbirth has, for men, both positive and negative aspects. Men generally expect to have a useful function during labour and, where this is facilitated, birth experiences are more positive. When fathers feel unprepared for the experience or feel unable to help, they find the process very difficult. Finding meaningful ways of actively involving fathers in the process of childbirth is likely to result in more positive outcomes for both men and women.

References

Bäckström, C., & Hertfelt Wahn, E. (2011). Support during labour: First-time fathers' descriptions of requested and received support during the birth of their child. *Midwifery, 27*(1), 67-73.

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC Medical Research Methodology*, *9*(59), 1-11. doi:10.1186/1471-2288-9-59

Bergström, M., Rudman, A., Waldenström, U., & Kieler, H. (2013). Fear of childbirth in expectant fathers, subsequent childbirth experience and impact of antenatal education: subanalysis of results from a randomized controlled trial. *Acta Obstetricia Et Gynecologica Scandinavica*, *92*(8), 967-973.

Britten, N., Campbell R., Pope, C., Donovan, J. Morgan, M. & Pill, R. (2002) Using meta-ethnography to synthesis qualitative research: a worked example. *Journal of Health Services Research & Policy, 7(4)*: 209-215

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Yardley, L., Pope, C. & Donovan, J. (2011) Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment, 15*(43). doi: 10.3310/hta15430

Chandler, S., & Field, P. A. (1997). Becoming a father - first-time fathers' experience of labor and delivery. *Journal of Nurse-Midwifery, 42*(1), 17-24.

Chapman, L. L. (2000). Expectant fathers and labor epidurals. *MCN: The American Journal of Maternal Child Nursing, 25*(3), 133-8. doi:10.1097/00005721-200005000-00006

Chin, R., Daiches, A., & Hall, P. (2011). A qualitative exploration of first-time fathers' experiences of becoming a father. *Community Practitioner: The Journal of the Community Practitioners' & Health Visitors' Association, 84*(7), 19-23.

Chin, R., Hall, P., & Daiches, A. (2011). Fathers' experiences of their transition to fatherhood: A metasynthesis. *Journal of Reproductive and Infant Psychology, 29*(1), 4-18.

Critical Appraisal Skills Programme (CASP; 2013) *Qualitative Research Checklist*. Retrieved from http://www.casp-uk.net/#!casp-tools-checklists/c18f8

Dellmann, T. (2004) "The best moment of my life": a literature review of fathers' experience of childbirth. *Australian Midwifery Journal of the Australian College of Midwives, 17*(3): 20-26.

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B. & Sutton, A. (2005) Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of Health Services Research & Policy,10*(1), 45–53.

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., Bonas, S., Booth, A. & Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *Journal Of Health Services Research & Policy*, *12*(1), 42-47. doi:10.1258/135581907779497486

Dolan, A., & Coe, C. (2011). Men, masculine identities and childbirth. *Sociology of Health & Illness, 33*(7), 1019-1034.

Draper, J. (1997). Whose welfare in the labour room? A discussion of the increasing trend of fathers' birth attendance. *Midwifery, 13*(3), 132-138.

Erlandsson, K., & Lindgren, H. (2009). From belonging to belonging through a blessed moment of love for a child - the birth of a child from the fathers' perspective. *Journal of Mens Health, 6*(4), 338-344.

Gabel, H. (1982). Childbirth experiences of unprepared fathers. *Journal of Nurse-Midwifery, 27*(2), 5-8.

Goodman, J.H. (2005) Becoming an involved father of an infant. *Journal of Obstetric, Gynelogic and Neonatal Nursing, 34:* 190 – 200. doi: 10.1177/0884217505274581

Greenhalgh, Slade & Spiby (2000) Fathers' coping style, antenatal preparation, and experiences of labor and the postpartum. *Birth, 27*(3):177-184.

Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. (2013) Continuous support for women during childbirth. Cochrane Database of Systematic Reviews, Issue 7. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub5.

Kaufman, M. (1999) Men, feminism, and men's contradictory experiences of power. In J.A. Kuypers (Ed.) *Men and Power.* (pp59-83). Halifax: Fernwood Books.

Kiernan, K. & Smith, K. (2003) Unmarried parenthood: new insights from the Millennium Cohort Study. *Population Trends, 114*: 26-33. Retrieved from http://www.ons.gov.uk/ons/rel/population-trends-rd/population-trends/no--114--winter-2003/population-trends.pdf

Kululanga, L. I., Malata, A., Chirwa, E., & Sundby, J. (2012). Malawian fathers' views and experiences of attending the birth of their children: A qualitative study. *Bmc Pregnancy and Childbirth, 12*, 141.

Kunjappy-Clifton, A. (2008). And father came too... A study exploring the role of first time fathers during the birth process and to explore the meaning of the experience for these men: Part two. *MIDIRS Midwifery Digest, 18*(1), 57-66.

Levant, R. F. (1992). Toward the reconstruction of masculinity. *Journal of Family Psychology, 5*(3-4), 379.

Longworth, H. L., & Kingdon, C. K. (2011). Fathers in the birth room: What are they expecting and experiencing? A phenomenological study. *Midwifery*, *27*(5), 588-594.

Matud, M.P. (2004) Gender differences in stress and coping styles. *Personality and Individual Differences, 37*, 1401-1415. doi: 10.1016/j.paid.2004.01.010

Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. *PLoS Med 6*(6): e1000097. doi:10.1371/journal.pmed1000097

Noblit, G.W. & Hare, R.D. (1988) *Meta-ethnography.* Thousand Oaks, CA: SAGE. Retrieved from http://srmo.sagepub.com/view/meta-ethnography/SAGE.xml

Premberg, A., Carlsson, G., Hellstrom, A., & Berg, M. (2011). First-time fathers' experiences of childbirth-A phenomenological study. *Midwifery, 27*(6), 848-853.

Ring, .N, Ritchie, K., Mandava, L. & Jepson, R. (2010) *A guide to synthesising qualitative research for researchers undertaking health technology assessments and systematic reviews*. Retrieved from: http://www.nhshealthquality.org/nhsqis/8837.html

Sapkota, S., Kobayashi, T., & Takase, M. (2012). Husbands' experiences of supporting their wives during childbirth in nepal. *Midwifery, 28*(1), 45-51.

Sengane, M. L. (2009). The experience of black fathers concerning support for their wives/partners during labour. *Curationis, 32*(1), 67-73.

Spencer, L., Ritchie, J., Lewis, J. & Dillon, L. (2003) *Quality in Qualitative Research: A framework for assessing research evidence.* London: Cabinet Office. Retrieved from http://collections-r.europarchive.org/tna/20070705130742/

http://www.policyhub.gov.uk/docs/qqe_rep.pdf

Singh, D. & Newburn, M. (2000) *Becoming a father: men's access to information and support about pregnancy, birth and life with a new baby.* London: National Childbirth Trust.

Somers-Smith, M. J. (1999). A place for the partner? expectations and experiences of support during childbirth. *Midwifery, 15*(2), 101-108.

Steen, M., Downe, S., Bamford, N. & Edozien, L. (2012) Not-patient and not-visitor: A metasynthesis of fathers' encounters with pregnancy, birth and maternity care. *Midwifery, 28*: 422–431

Thomas, J. & Harden, A. (2008) Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology, 8(45),* 1471-2288. doi:10.1186/1471-2288-8-45

Walsh, D. & Downe, S. (2006). Appraising the quality of qualitative research. *Midwifery, 22,* 108-119. doi: 10.1016/j.midw.2005.05.004

Chapter 2: Empirical Paper

The Experiences of Fathers Who Found Childbirth Traumatic

Manuscript prepared for submission to the Journal of Clinical Psychology in Medical Settings (see Appendix D for Author Guidance)

Abstract

The study explored the experiences of men who found childbirth traumatic. It investigated how men coped with these experiences; the impact on their lives; and their views on what may have helped to reduce their distress. The study employed a qualitative design. Eleven fathers completed an online measure of trauma symptoms and took part in a semi-structured telephone interview. Template analysis was used to interpret the interview data. Childbirth was experienced as "a rollercoaster" of events and emotion involving fear, distress at the partner's pain and helplessness. Fathers often found themselves abandoned with a lack of information. Men were subsequently distressed and preoccupied with the birth events but tended to feel that a trauma response was not justified and tried to cope through avoidance, which often had a negative impact on their relationships. Men described the need for support but reluctance to receive it. Implications for maternity care are discussed.

Keywords: childbirth, fathers, qualitative research, trauma

Introduction

Men are susceptible to a range of mental health problems following the birth of a child (Bradley & Slade, 2011). Paternal mental health difficulties have been shown to increase the risk of emotional and behavioural problems in children (Ramchandani & Psychogiou, 2009) and affect the relationship with the partner (Parfitt & Ayers, 2009). Most of the research into men's mental health following childbirth has focused on post-natal depression (Bradley & Slade, 2011); however, anxiety may be the most common post-natal mental health problem experienced by new parents (Wynter, Rowe & Fisher, 2013).

Research indicates that up to seven percent of women may experience symptoms of post-traumatic stress after childbirth with prevalence for full PTSD estimated at between one and two percent (Ayers, Joseph, McKenzie-McHarg, Slade & Wijma, 2008), with subjective distress during labour and obstetric emergencies being the most significant risk factors (Andersen, Melvaer, Videbech, Lamont & Joergensen, 2012).

Post-traumatic stress symptoms in men following childbirth is a less explored area of research. Due to the limited research in this area the prevalence of Post-Traumatic Stress Disorder (PTSD) after childbirth in men is difficult to quantify; with studies finding symptoms in between zero and five percent of the populations sampled; between six and nine weeks post-partum (Ayers, Wright & Wells, 2007; Bradley, Slade & Leviston, 2008). However, Ayers et al (2008) - in their symposium on PTSD following childbirth - highlighted that studies of fathers have relied on questionnaire measures and have failed to assess the full diagnostic criteria for PTSD. Consequently, there is very little that can be stated with certainty about the prevalence of PTSD in men following childbirth and it is an area for further research.

Qualitative research into women's experiences has found that they may report trauma responses to births which are viewed by medical professionals as routine (Beck, 2004). The subjective nature of the experience is the crucial factor (Garthus-Niegel, von Soest, Vollrath & Eberhard-Gran, 2013). Given that men are increasingly present throughout labour and birth (Kiernan & Smith, 2003) and that men's post-traumatic responses influence those of their partners (Iles, Slade & Spiby, 2011), understanding their experiences and responses is important.

Qualitative literature into men's attendance at routine childbirth has identified that they experience uncertainty about their role, feelings of helplessness at the inability to support the partner in pain, but ultimately joy at the birth of a healthy child (e.g., Kunjappy-Clifton, 2008; Premberg, Carolsson, Helström & Berg, 2011). However,

there is little research on the lived experience of men who have found attendance at childbirth traumatic. Nicholls and Ayers (2007) studied the impact of PTSD on couple relationships, which included three men who had PTSD following childbirth. They found that lack of control and care were important aspects of the birth experience and that couples' relationships were negatively affected by the impact of the birth events. White (2007) attempted to explore men's experience of PTSD after childbirth through the narratives of fathers who had witnessed a traumatic birth, finding that men felt alienated through being "a spectator", rather than having a role in the birth, and excluded by the actions of staff. Men reported feeling very distressed during the birth but tried to keep this hidden. The experience had an impact on the subsequent sexual relationship with the partner, which was described as "sexual scarring".

White's (2007) study provides helpful insight into some of the experiences of men during traumatic childbirths. However, there is scope for further exploration. White relied on narratives given by fathers therefore there was no opportunity to investigate the experiences in greater detail. In addition, although she was interested in PTSD, there was no screening interview or measure of post-traumatic stress symptoms and not all of the participants showed symptoms of PTSD. Furthermore, there was little information on the wider impact of the experience and how men tried to cope with the trauma of birth.

Aims

The limited literature in this area indicates that some men may experience symptoms of post-traumatic stress as a result of childbirth. There is very little research on experiences of men who found childbirth traumatic, whether or not they go on to develop symptoms of post-traumatic stress. This study aimed to explore this phenomenon. The particular areas of investigation were: the factors that contributed to making the experience traumatic; the impact of the experience on the fathers in terms of

their behaviour, relationships and how they tried to cope with the trauma; and what they believed could have supported them through the experience.

Method

Participants

Eleven men, aged between 27 and 45 years old *(M* = 36.36 years; *SD* = 4.63), participated in the study. Men were included in the study if they were resident in the United Kingdom; aged 16 or older; had been present for the birth of the child; and described a trauma response to the birth according to criterion A2 of the revised fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R, American Psychiatric Association (APA), 2000). Men were unable to take part if their partner or baby had died or their child had spent more than seven days in neonatal intensive care following birth. All were first-time fathers at the time of the birth they had found traumatic; two men had gone on to have subsequent children. Seven were married, three were cohabiting and one man was engaged. All were employed, although one was on sabbatical from work. Two men had received previous treatment for depression, including medication and talking therapies. Both of these men had also accessed support from their GP following their childbirth experiences. Time since birth ranged from two months to six years. Participants were recruited via an advertisement (see Appendix E) displayed on the Birth Trauma Association website; in a newsletter of the Fatherhood Institute and on two internet forums: www.dadsnet.net and www.mumsnet.com between November 2013 and June 2014. Figure 1 illustrates the flow of participants through the study.

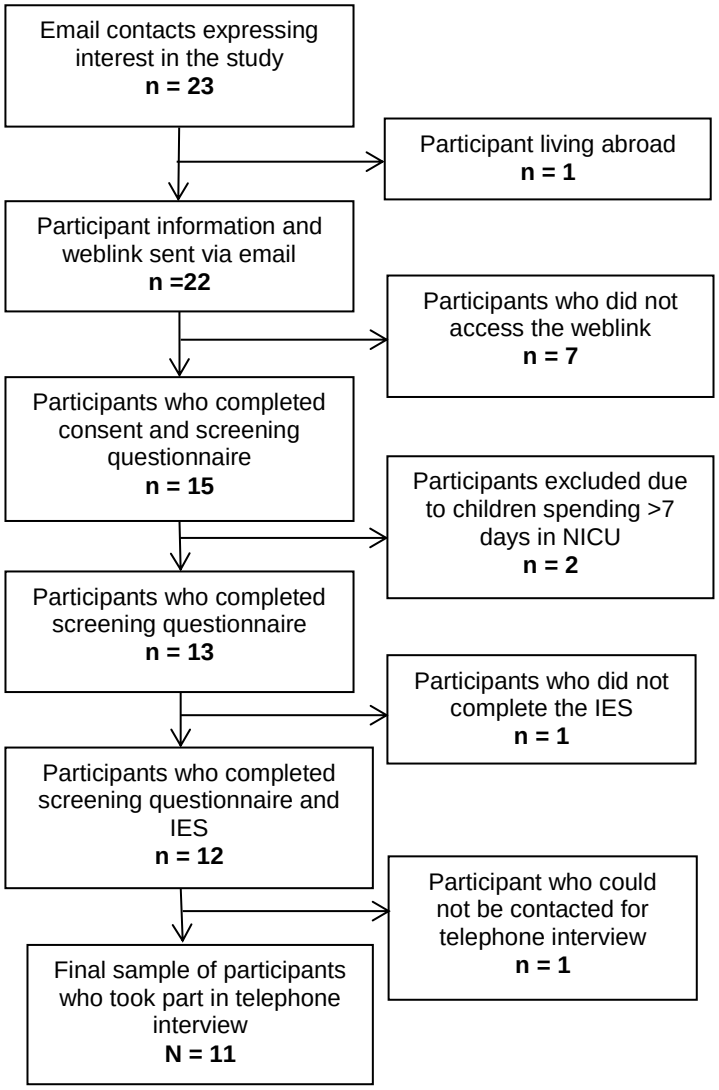


Figure 1 Response rates throughout recruitment and interviewing processes

Note. IES = Impact of Event Scale (Horowitz, Wilner & Alvarez, 1979)

Measures

The Impact of Event Scale (IES) was selected as the sole measure for the study. The purpose of the questionnaire was to describe the participants, rather than to select those who scored above a cut-off score. This was to allow for the possibility that men who describe experiencing a birth as traumatic may not proceed to develop symptoms of post-traumatic stress. Additional measures of mood or anxiety were not considered for this study, primarily due to the focus of the study being the men's qualitative descriptions of their experiences but also because the inclusion of further measures could have been off-putting for participants.

Impact of Event Scale (IES; Horowitz, Wilner & Alvarez, 1979).

The IES (see Appendix F) is a well-established measure for assessing the presence of trauma symptoms. The 15 questions measure experiences along two axes: intrusion and avoidance. Higher scores indicate more severe symptoms. The IES has been demonstrated to have good reliability (intrusion mean α=0.86; avoidance mean α=0.82) and validity (Sundin & Horowitz, 2002).

Interview schedule.

A seven-item semi-structured interview schedule (see Figure 2) was devised based on the areas of interest in the study. The interview schedule also drew on some of the questions and themes used by Nicholls and Ayers (2007). Following the first four interviews, two additional questions were included.

Interview schedule

- Age; employment status; marital status
- Time since birth; mode of delivery; how many births attended;
- Mental health history and service use

1. **What was the experience of being at the birth of your child?**
   Prompts: events; thoughts; feelings; worst parts.
2. **What difficulties have you experienced following the birth?**
   Prompts: course of experiences over time; which experiences are most distressing/difficult
3. **In what ways, if any, have these difficulties affected you and your partner?**
   Prompts: work, wider relationships, engagement in activities;
4. **What things have you tried to help you manage how you've been feeling?**
   Prompts: done anything differently than before the birth; accessed any support; does partner know how you feel;
5. **How has your relationship with your partner been since the birth?**
   Prompts: changes in relationship pre/post birth; level of satisfaction with the relationship
6. **How has your relationship with your child been since the birth?**
   Prompts: expectations vs. reality
7. **Is there anything that could have made your experience less difficult?**
   Prompts: before, during or after birth

Questions added to the schedule following first four interviews:

8. **What has it been like talking about your experiences?**
9. **What motivated you to take part in the study?**

Figure 2 Semi-structured interview schedule.

Design

A qualitative methodology was employed using semi-structured interviews to explore men's experiences of childbirth as traumatic.

Procedure

Ethical approval for the research was granted by the University of Liverpool Research Ethics Committee (Reference number: RETH000644, Appendix G). Participants who responded to the study advertisement were sent a standard email response (see Appendix H) with a weblink to access the online part of the study using a unique identity code and the participant information sheet (see Appendix I). Participants who accessed the website completed a consent and screening questionnaire (see Appendix J) confirming that they met the eligibility criteria. This included one question to assess for criterion A2 of the diagnostic criteria for PTSD (DSM IV-R, APA, 2000): "At some point during the child birth I experienced intense feelings of fear, helplessness or horror". Participants who confirmed these questions were able to progress to the IES, which they were asked to complete with regard to the experience of childbirth. Participants were then asked to provide a telephone contact number and preferred days and times for a telephone interview.

Participants were contacted for interview at the preferred times they had indicated online and interviews were audio recorded. To begin, participants were asked to confirm they had understood the participant information; reminded of their right to withdraw and asked to confirm that they wished to continue with the study. Participants were also given an opportunity to ask any questions. Interviews then proceeded following the semi-structured schedule.

Interviews were between 28 – 87 minutes in length. At the end, the researcher gave participants another opportunity to ask questions. Participants who had not already accessed support were reminded of the information given prior to participation that help could be sought from their GP. In accordance with ethics requirements, the men were asked for consent to contact them via email within the following week in case the study had raised any queries for them. All consented to this but no difficulties arose.

Participants were also reminded of the researchers' contact details should they have had any queries after the interview.

At the end of each interview, the researcher made brief notes on the experience of being the interviewer (see Appendix K for an example) which were considered during the analysis.

Analysis of Interviews

The telephone interviews were analysed using template analysis. Template analysis is a form of thematic analysis, which can be adapted to suit the epistemological stand point of the researcher and incorporates elements of top-down and bottom-up analysis (King, 2004). This method was selected over Interpretative Phenomenological Analysis (IPA) as it has a greater focus on between-case analysis and allows the researcher, through the use of *a priori* codes, to acknowledge specific areas of interest prior to beginning analysis.

Template analysis.

Template analysis differs from other forms of thematic analysis in that a priori themes in an initial template, drawn from existing theory, the research questions, or a sub-set of the data can be used to guide the analysis. However, the initial template is revised as emergent themes are drawn from the data. King (2004) describes four main actions by which the template is revised: Insertion of new codes where existing codes do not capture data relevant to the study; deletion of codes that are found to be redundant; changing the scope of the code i.e., changing the level at which it appears in the template; and changing the higher order classification i.e., moving a subtheme from one higher order code to another. Through this iterative process, the final template is developed. Template analysis is further explored in Appendix L.

The initial template is shown in Figure 3. As suggested by King (2004) it followed the structure of the interview guide. Template analysis is concerned with the

relationships between codes and themes, which is represented in the hierarchical structure. Using these higher-order themes as a guide, the interview transcripts were analysed for emerging sub-themes. Each interview transcript was read several times to become familiar with the data. Transcripts were then annotated with emerging codes which were added to the template (see Appendix M for example of coding). The first and second authors read and coded the first three transcripts independently before comparing the analyses, which were found to be consistent. Both researchers met again once all of the transcripts had been analysed to discuss the relationships between themes and the organisation of the final template. The template was continually revised throughout this process, with additional themes and subthemes inserted, deleted or collapsed under a new heading as the analysis progressed until the final template was developed.

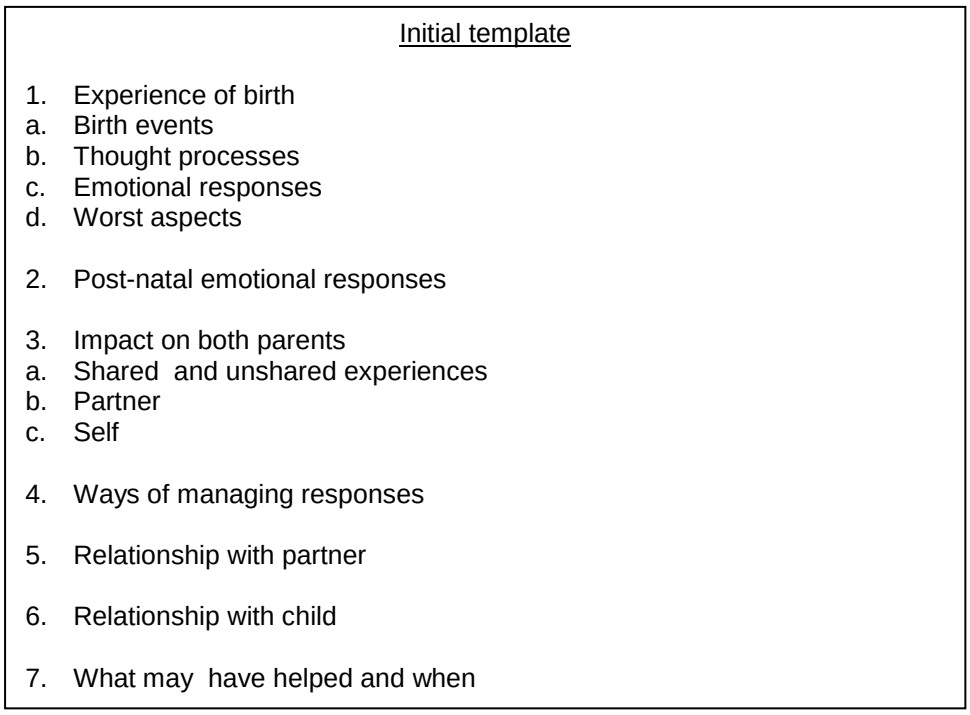


Figure 3. Initial template, based on the interview schedule.

Results

All eleven participants described births in which obstetric complications had arisen (see Table 1).

Table 1. *Birth details*

Participant	Single/multiple birth	Mode of delivery	Pain relief	Complications
F1	Multiple	Emergency c-section	Spinal anaesthetic	Haemorrhage
F2	Single	Vaginal; forceps delivery	Gas & air; local anaesthetic	Episiotomy; anaesthetic administered incorrectly.
F3	Single	Emergency c-section	Epidural	Lost pessary; venflow administered incorrectly; ruptured retained placenta
F4	Single	Vaginal; forceps delivery	Gas & air; epidural	Haemorrhage
F5	Single	Emergency c-section	Epidural	Haemorrhage; hysterectomy
F6	Single	Emergency c-section	Epidural	Epidural not fully effective; lost swab
F7	Single	Ventouse	Gas & air	Ventouse; umbilical cord around baby's neck
F8	Single	Emergency c-section	Anaesthetic	Premature
F9	Single	Vaginal delivery	Not known	Haemorrhage
F10	Single	Emergency c-section	Epidural	Abrupted placenta & internal bleeding
F11	Single	Emergency c-section	Pethidine	Haemorrhage

Responses to the IES were used describe the sample. Results are shown in Table 2. Higher scores on the IES indicate greater severity of traumatic stress symptoms, with scores over 35 suggesting possible PTSD (Neal et al., 1994). Three of the participants scored 35 or over. Eight of the 11 men scored higher for the avoidance items than intrusion.

Table 2. *Impact of Event Scale scores*

Participant	Total IES score	Intrusion subscale	Avoidance subscale
F1	44	29	15
F2	28	6	22
F3	35	11	24
F4	22	8	14
F5	29	11	18
F6	0	0	0
F7	7	4	3
F8	7	1	6
F9	27	13	14
F10	41	15	26
F11	27	10	17

Template Analysis

The final template is illustrated in Figure 4. An earlier iteration of the template is included in Appendix N. Seven higher-order themes, of which three were emergent from the data, were identified: experience of birth; impact on self; "Nothing's actually happened to *me*"; putting it "in a box"; relationships; desire for resolution; and what might have helped and when. All of the subthemes were emergent. Appendix O illustrates data from the participants organised within the levels of the template. The themes from the template are discussed below. Care was taken to look for disconfirming evidence in the data and where this was found it is highlighted.

Final template

1. Experience of birth
    1. Rollercoaster of events and emotion
        i. Rapid changes in events and environment
        ii. Multiplication of stressors
    2. Emotional aspects
        i. Fear of death
        ii. Distress at partner's pain
        iii. Keeping control of emotions
        iv. A bystander to a catastrophe
    3. Isolation/ abandonment
        i. During the birth
        ii. Being sent away
    4. Loss of positive/ shared experiences
        i. Lost first moments
        ii. Dividing attention
    5. Staff and system responses
        i. Dissatisfaction with care
        ii. Communication
    6. Distortions of perception

2. Impact on self
    1. Disconnection
    2. Preoccupation
    3. Work
    4. Less emotional control

3. 'Nothing's actually happened to *me*'

4. Putting it "in a box"

5. Relationships
    1. With partner
    2. With child

6. Desire for resolution

7. What may have helped and when
    1. Being prepared
    2. Staff responses
    3. The challenge of delivering support
        i. Men are overlooked
        ii. Tension between wanting help and being seen to take it

Figure 4. Final template

1. Experience of the birth.

The fathers' narratives indicated that they found the experience of birth one of constant shift and change, both in terms of situational aspects and emotional content. In recalling events, the men's descriptions were frequently vivid and detailed. One father recalled how his wife's blood "splashed up and hit the surgeon in the face", likening the

scene to an "abattoir" (F1). Another spoke of "the scream that came out of [his wife's] throat" (F2); whilst another father recalled the contrast of holding his new born child in a room full of medical equipment with "blood dripping onto the floor" (F9).

1.1 "A rollercoaster".

Most fathers referred to rapid shifting of events and emotion during the birth. These continual fluctuations created an impression of labour and childbirth as "a rollercoaster" (F10), comprising two main aspects: the suddenness and speed of situational changes and accumulation of stressful events.

1.1i Rapid changes in events and environment.

Several fathers described thinking that the labour would go well and without difficulty: "I just thought it's like one of those processes that happens and there'll be no complications." (F5); and that initially "everything seems to be progressing well" (F11) and there was "no reason for concern" (F6). Other fathers had anticipated that the birth may be more complicated; however felt unprepared for the scale of difficulty: "our expectations perhaps that things wouldn't all be straightforward, I didn't feel quite prepared for the, er, turn of events" (F10). Lack of preparedness for a difficult birth meant that the suddenness with which events changed was key: "It just descended from being very straightforward to very traumatic very quickly" (F6).

The influx of additional medical staff with "more and more people turning up" (F3) to the labour room was recalled in many of the narratives as a sign that the situation had become urgent. This often seemed overwhelming: "it felt like 30 people in the room" (F2) and one father felt he was "pushed back" (F7) rather than being able to stay by his wife, as he wished. The speed with which events took place contributed to a sense of disorientation and uncertainty: "she was whizzed off down to theatre" (F5) and "suddenly…two minutes later we were in a delivery room and there's a caesarean going on" (F10).

1.1ii Multiplication of stressors.

Several fathers described continual fluctuations of experience, from thinking that "we were over the worst of it" (F3) and "on the home strait" (F10), when the baby was born or the labour seemed to be under control, to then experiencing further stressors with concern about the health of either the baby or their partner. This short-lived relief and the cumulative effect of stressful events and shifting experiences was illustrated by one father:

> And it's like this pull, push, pull, push, pull, push, in, out. Over, back of what's happening; what's not happening; what could happen; what might; what you thought would happen; what's not (F1)

This rollercoaster effect was a thread running throughout many of the narratives creating a level of uncertainty, anxiety and helplessness with which the fathers found it difficult to cope.

> All the kind of stuff that went on before that and all the stuff that went on after that might not have been that significant in themselves but when it's all put in the mix together it just multiplies up (F3).

As indicated by this father, not all of the stressful events seemed traumatic in themselves but the layering of these incidents onto one another created a build up of stress for the men. Both situational and emotional aspects added to this. The partners of four men experienced medical mistakes such as pain relief being administered incorrectly, which added to the pain experienced and increased both the mothers' and the fathers' stress. Others recalled a lack of care from staff, or the experience of waiting for news and information. These layers are explored in the following themes and subthemes.

1.2 Emotional aspects.

Men described overwhelmingly negative emotions throughout most of the labour and birth. In spite of this, they tried to contain their feelings in an attempt to protect their partners from further distress.

1.2i Fear of death.

Fear and anxiety were the most common emotional responses. Most described fears that their partner or baby would die, which one father experienced as "my whole life sort of in some kind of pivot" (F9), between the possibility of having to raise his child alone or with his partner if she survived, which was echoed by other men "You know, at one stage I was thinking, 'shit, I'm going to bring up a child on my own'" (F11). The strength of feeling was illustrated by the powerful language fathers used, referring to themselves as "terrified" (F9 and F10). These fears often arose from the men's perception of what was happening: "from what was going on, y'know, the amount of people in the *room* and what she was looking like and what they were doing and all that kind of thing, I was thinking "oh god, this is 50/50" (F4).

1.2ii Distress at partner's pain.

The pain of the woman and her suffering had a direct effect on the man as his distress mirrored hers: "the more that she was obviously in distress the more I became distressed on her behalf" (F6); "it just really hurt to see her in so much pain" (F2). The experience for one father of hearing "for an hour my wife screaming in the room next to me and I wasn't able to do anything about it" (F3) was the most traumatic aspect of the birth and relates to the theme of helplessness, which is described later.

1.2iii Keeping control of emotions.

Seven fathers referred to "trying to keep it together and be strong for [partner]" (F8), although this belied the emotion they were really feeling: "I wasn't calm in my head but outwardly I was" (F7). This seemed to be motivated

by the belief that, for the woman, seeing her partner upset was "not going to do her any good at all" (F9). Most of the men tried to hide their feelings but some were so overwhelmed by the experience that they could not maintain this façade and "broke down" (F11). Others were able to contain their emotion during the birth but became extremely distressed when on their own and "just broke down in tears" (F5).

1.2iv A bystander to a catastrophe.

A "feeling of utter helplessness" (F7) came through many of the interviews, with one father likening the experience to "watching a, yeah, a car go off a cliff and, you know, you're just slightly too far away to actually do anything about it and you just sort of stand there and watch it all happen" (F4). Perceiving themselves unable to do anything practical, alongside uncertainty from a lack of information and understanding of what was happening, also left the men feeling helpless: "I felt helpless and I thought 'I don't know what's going on'" (F10). This was in contrast to their usual experiences of feeling in control: "I spend a lot of my life being in control of stuff and looking after stuff and managing stuff……I was in a situation where I was, er, I felt like I was…totally out of control" (F8).

Consequently, the men had to put their trust in the health professionals, which gave them a sense of unease: "There's just nothing you can, you can do to sort of change what's gonna happen and sort of thing. It, it's up to somebody else to sort of sort out, or not as the case may be" (F4). Linked to the feeling of helplessness was the fact that the men were acutely aware of what was going on around them; in contrast sometimes to their partners: "but at the same time I'm sitting there and *I'm sitting there*. There's no drugs in me, I'm not anaesthetised in anyway" (F1).

1.3 Isolation and abandonment.

For several fathers, the experience of being present at the birth involved a period during which they were abandoned or isolated.

1.3i. During the birth.

Men often found themselves alone either while their partner was being prepared for a surgical birth or when she was being attended to by medical staff after the birth. This was another layer of stress, adding to the rollercoaster experience. They recalled feeling "lost" (F5). As described previously, for one father the experience of abandonment was intensified as he could overhear his wife's screams in theatre whilst he was left in the next room, alone. The men gave stark examples of how isolated they were at times:

> Suddenly, erm, I'm just handed the baby and, er, and [partner] and these ten or twelve people shoot out of the room……literally everybody left (F9);
>
> So I was just then left in that room on my own and I was in there for, I was in there for over and hour (F3);
>
> I remember guessing it was about 50 minutes, they brought [baby] and gave me her, er, wrapped in a towel and disappeared. Everyone disappeared again (F10).

This isolation increased anxiety and uncertainty about what was happening, intensifying the men's fears that something was wrong:

> They took me and, er the babies back to a room whilst they said they were going to clean [wife] up a bit and what have you…It took about..it took her about half an hour then to reappear so y..I thought "what the <u>hell</u> is going on here?" (F1).

1.3ii. Being sent away.

For some, a sense of abandonment was felt keenly when they were told to leave the hospital after visiting hours and were left alone but very upset; "When they sent me home at two in the morning and I remember just sitting in the kitchen for hours in bits" (F9). The experience of being sent away from their partner and child was very difficult for the men "'There you are. Go. And don't come back in the morning til ten o'clock.' Very, I found that *so* difficult" (F7). This was sometimes compounded by the emphasis from staff that facilities were for the mother and child only, not for men.

A notable exception to this was the man whose wife was very ill after childbirth and who was allowed to stay with her in hospital; being treated almost as another patient.

1.4 Loss of positive, shared experiences.

A consequence of the nature of many of the births was that some of the first moments with their child, which they had envisaged being shared, joyful events, were lost. They also found themselves in the position of having to negotiate dividing their time between their partner and baby.

1.4i Lost first moments.

Five men made specific reference to the loss of anticipated positive experiences as a result of what happened during the birth. For some, the situational aspects and stress of what was happening left them with a sense of regret that they had missed out on the anticipated "magic moment" (F3) of birth. For others, the medical attention needed by their wife meant that some of the things that they had expected to do with their wives were done alone; "I just anticipated that we'd do it together" (F9*).* This was made more difficult when the men were aware that their partner would have wanted to do things such as change the first nappy and give the baby the first bottle. For some men, their partner's physical condition after the birth meant that they had to continue as

the primary carer for the baby for some time after birth, which was a positive experience but one "tinged with guilt" (F10) that their partner would have wanted to do it.

1.4ii Dividing attention.

Fathers spoke of "flitting between" their partner and child (F10) and feeling that they were "torn between two posts" (F3). One father reported that he "couldn't really comfort [partner] because I was holding the baby" (F5), whilst another did not want to leave his wife in theatre to go with his new-born daughter (F11). This was yet another stressor that men felt subjected to in the rollercoaster of events. Although most of the fathers felt that the loss of shared experiences was a negative consequence of the birth, one man stated that although "there was no enjoyment of the moment" he did not think that this was a problem because "you can't miss what you've never had" (F10). In addition, one man acknowledged that it was a "special thing…to be there for [baby]" (F9).

1.5 Staff responses.

For some men, interactions with health professionals contributed to their distress during the birth.

1.5i. Dissatisfaction with care.

Five men described difficulties with staff due to feeling "dismissed" or perceived lack of care: "I didn't really feel like we were getting much help" and the midwife was "horrible" (F3), causing this to be central to finding the experience traumatic. One father expressed anger towards staff at their perceived negligence: "that became very mixed up with emotions of sort of anger, like 'what on earth d'you think you're doing?' y'know? 'Why…how could you possible have been so negligent to do that?'" (F6). Lack of sensitivity in the way staff spoke to either of the parents also caused distress for the men. One father described himself as "destroyed" (F7) by a comment from the midwife and another felt his partner's difficulties were not

acknowledged by staff, telling her "we have women who've had c-sections in here and they're up and about" (F9).

1.5ii Communication.

Some men were very angry about how they had been treated; others recognised the difficulty for staff of attending to them and giving information whilst they had a job to do in looking after the woman and child. However, they would have liked more communication. One father recalled vividly the sight of his daughter being "smuggled away" (F1) by staff as they tried to revive her, without acknowledging to him that she had been born:

> Nobody said anything. You know, that's…even if the child was born and was dead I would've expected them to say something. Not just disappear around the corner. And, and because they didn't, you kind of have to…where I was at the time I think "There must be a reason they're not saying something. There must be a reason".

Other men expressed the difficulty of "waiting and waiting and waiting for *something*, for some information" (F8) and having "no explanation of anything" (F3) during the birth. Participant eight understood this as resulting from the fact that "this is very mundane for [staff] and they understand what's happening and you don't".

In the absence of communication from staff, some men tried to infer from body language or their surroundings what was going on. This included "scanning for clues" (F8) in the operating theatre or trying to read the body language of the medical staff. Some men gave positive descriptions of how staff had communicated with them through the birth, which gave them reassurance, but also reflected that there were times when they would have liked to have known more about what was happening.

1.6 Distortions of perception.

Some men reported changes in perception and a "heightened awareness" (F1) as the events of the birth took place. Most common was a sense of everything taking a long time; it "felt like forever" (F5); "it felt like about three days" (F3). This was usually in the periods when fathers were waiting for information and separated from their partners. Others reported the experience as "surreal" (F10) and that everything happened in "a blur" (F11) and "didn't really register properly" (F4). Another described "the feeling of being *removed* slightly from the reality but still…you're *there*; it's *very* real. It's *so* real that it's unreal" (F1). Some of these effects continued to impact upon the men after the birth, as described in the following section.

2. Impact on the father

Most fathers indicated that the birth experience had had some impact on them, to greater or lesser degrees. For some their distress continued to be acute, whilst for others the impact had lessened over time.

2.1 Disconnection.

For some, the feeling of disconnection which had begun with the distortions of perception during the birth continued afterwards. The degree of disconnectedness ranged from being "completely shocked" (F7) and "stunned" (F1), to going onto "autopilot" (F10), to the man who "went off into some weird twilight zone kind of thing, I think…I sort of, not zoned out for six months but sort of…I had an odd reaction" (F4). This was in part related to how the men tried to cope with the enormity of the experience of birth, which is described later.

2.2 Preoccupation.

Preoccupation with the events of the birth continued in the weeks, months and even years afterwards; being "still fresh in my mind" (F11). Rumination was a feature for some men who found themselves "going over and over" (F3) what had occurred,

with one father even trying to imagine what pain his partner must have been in. External stimuli, such as television programmes and stories of babies being born, triggered their memories of the birth and as a consequence they tried to avoid them. Some had "flashbacks" (F7) to the birth or relived it in their dreams. At the most severe end of this continuum, was a father who described such intrusive thoughts of the birth that, a year on, he never went to bed "because even if I go to bed, even still the events of [the birth] go round and round and round in my head" (F1), preventing him from sleeping. Two fathers identified that the birth had had a delayed impact on them. They were both men with a previous history of depression, which after a period of around twelve months of coping, they felt was returning.

2.3 Work.

For some men, the birth experience and its personal consequences adversely impacted up on their work. One father who described himself as previously very dedicated to work explained that he had had his "least productive twelve months" (F9) since first being employed; another had reduced his workload due to difficulties concentrating, and one man had taken a sabbatical from work "I kind of got to the point that I said, look I need to stop work for a bit and…take some time out" (F8). In contrast, participant four took refuge in his work; attempting to retain some normality through the belief that "I'll just go back to [work] and everything will be fine"; another found work a helpful distraction.

Some men commented on their reluctance to discuss their experiences, particularly with their colleagues: "We're like a lot of males, male-orientated and, sort of, like you don't want to show your emotions and like it's all a bit of a laugh. You make a joke of things all the time" (F5). The expectation that others may not understand or would dismiss their distress also affected how fathers shared their experiences of the birth.

> There's no point going to work and saying "My head is all over the shop because of what happened back here" and, y'know, and it's like you can't say that to somebody who's looking at the photo of your two beautiful new-borns. And they're looking at you and "you should be pulling yourself together, forget about that now" (F1).

2.4 Less emotional control.

Men described feeling "much more emotional" (F5) and that this was unpredictable. Often they were unsure whether this was an effect of being at the birth, or a normal response to becoming a parent but it was usually felt as inappropriate. Participant ten recalled becoming emotional over a story he heard on the radio, explaining "that made me kind of go into tears. I thought, that's not, that's not right, I mean it's a lovely story but…".

3.'Nothing's actually happened to <u>me</u>'.

Although for many of the men the experience of birth had a significant impact on them, several fathers indicated that they did not feel that they had a right to be affected because "nothing's actually happened to *me*" (F5). The experience of witnessing and being part of the birth seemed almost to be dismissed as an event because it was emotional, rather than physical: "I felt guilt…that I was feeling traumatised when, you know, obviously I hadn't really gone through anything" (F11). Intertwined with this idea was the concept of masculinity and what the fathers expected of themselves. As one man explained, "someone had to be the strong one" (F8) and "there's no room, if you like, for me feeling sorry for myself, or, or having time to be a patient" (F1). Fathers felt that as they had not physically given birth it was their responsibility to "get on with it" (F1). These beliefs dictated the coping strategies that the men employed to deal with the effects of the birth.

4. Putting it "in a box"

The men's coping strategies seemed, in general, to be dictated by their beliefs about acceptable masculine roles such as stoicism, keeping emotions to themselves and being strong for others. Avoidance was the dominant theme and was evident at some level even for the men who spoke of their difficulties as resolved. Fathers referred to having "bottled it up" (F8) or "putting it in a box" (F1) and not "wanting to get into it too much" (F10) . This occurred along a continuum from avoiding thinking or talking about the birth to the father mentioned previously who described himself as in a "twilight zone" (F4) for several months after the birth.

This also related to the idea of getting on with it, as mentioned. This included elements of avoidance, such as hiding feelings from their partners because "I'm a big lad, I can look after myself" (F1) and not wanting their partner to "know how scared I was that night" (F5). Fathers tended to focus on the present and getting through each day, at the cost of addressing their emotions about the birth. However, most did acknowledge that, as a coping strategy, this had potential negative consequences. One father who described himself as "falling to pieces" as a delayed impact of the birth explained "I kind of wonder if that's because it had just been bottled up and held and like 'come on, get on, get on, get on, get on, deal with it'" (F8).

There were some exceptions to avoidance. One man had forced himself to think about the experiences as a way of dealing with them. Another tried occasionally to "make [him]self watch" (F9) programmes about birth to help him deal with his feelings. Participant eleven described an almost desperate search for some context in which to understand his experience, "anything that could help me process what, you know, that, that day". Two fathers had sought help for their distress. Interestingly, these were both men who had a previous history of depression. Both described being aware of the signs that they were having difficulties with their mental health and both had also had some

form of counselling or talking therapy on previous occasions. However, both had reached a significant level of distress before seeking help.

5. Relationships.

The experience of the birth had various consequences, both positive and negative on the men's relationship with their partners and children.

5.1 With partner.

For some men the experience of the birth had a positive impact, including a deepening of feeling for their partner and the relationship taking on a new dimension: "I think her, her having such a kind of intense experience, it also brought home to me the fact that she was not just my wife any more, she was also the mother of my child" (F6). For others, the impact of the birth and how the men tried to cope with it acted as a barrier in the couple's relationship. One man's attempts to cope with his distress by withdrawing and hiding his emotions resulted in his partner perceiving that he was "blasé……that I didn't care too much about what had happened" (F5). Other partners felt unsupported and, in some cases, the level of disconnection was such that there was "nearly no relationship there now" (F1).

The partner's response to the birth also affected how the man felt. One explained that "it helped me to see her dealing with it" (F2), whilst for others the on-going emotional or physical effects of the birth on their partner prolonged their distress and it was "difficult to deal with her dealing with it" (F3). In some couples, the men and their partners had very different mechanisms for coping with the experience and some of the men commented on the very different perspectives that they had each had of the birth as "she didn't see it from this angle" (F10).

For three men the experience had affected their feelings about future pregnancies. For one, "talk of another child means it's all coming back" (F11); other fathers doubted their ability to cope: "It made me wary of the process of the delivery

and where it might put me. And if I was to have that experience again, would it be worse? Could I cope?" (F7). This had impacted on some of the relationships in that their partners had wanted to have more children sooner.

5.2 With child.

All bar one of the men described that, in spite of the traumatic experience of the birth, their relationship with their child was, for the most part, positive and "I utterly adore him" (F6). Some of the men believed that the difficult experience of the birth and the effects on their partners had a positive consequence on increasing their bond with the baby, particularly if they had had to take on the role of primary carer for a period after birth; "I got very good at being hands on and doing it all right from the start" (F10).

One exception was father 4, who felt that his relationship with his child was "uneasy", which he attributed to the impact of her birth on him. He described himself as "zoned out" through the early months of her life and thought this was the cause of their lack of close relationship. The impact for him was long-lasting as his child was almost seven years old.

6. Desire for resolution.

A minority of the men felt that their difficulties with the birth were resolved; however for most there was a sense that something endured which was yet to be addressed. For some, the fact that things had still not "got back to normal" (F1) and the effects of the birth were "still front and centre in our life" (F3) compounded the difficulties for them. Others felt that, although the impact on them had reduced, there was a lingering effect, "a cloud" (F10), and that the experiences still needed "straightening out in my head" (F9).

7. What might have helped and when

Two main aspects could have reduced men's distress: being prepared and the responses of staff and the health system. A third theme arose from the men's comments: the need for support yet the difficulty of providing it to men, who are loathe to be seen seeking help.

7.1 Being prepared.

Three men suggested that being aware that there could be difficulties would have reduced their distress during the events. Most had not anticipated anything other than a straightforward birth, suggesting that knowledge that labour and birth is "not risk free" (F5) could have helped. An antenatal class demonstration of a surgical birth had helped one father feel reassured when he came to experience one. However, one man thought that "nothing can prepare you for it" (F8).

7.2 Staff and system responses.

Six men indicated that there were things that staff could do to help them through the process. They generally thought that better communication would have been helpful although they acknowledged the difficulty of doing this during the labour. However; most felt that after the birth "just having someone to talk to" (F7) and "anything that could maybe help me process what, you know, that, that day" (F11). Following a difficult birth, fathers also desired acknowledgement from staff that it "wasn't normal" (F1) and could be difficult for the man. Two fathers had had postnatal debriefs; another had decided with his partner to ask to view the medical notes in an attempt to help him process what had taken place during the birth. It seemed important to the men to be able to gain some context for their experience in order to be able to deal with it.

7.3 The challenge of delivering support.

There was a tension and contradiction in the men's responses to the question of what would have helped them, which was that they expressed that there should be more support for fathers but also that men would be unlikely to access help.

7.3i Men are overlooked.

Most men seemed prepared for the attention during birth and immediately afterwards "all rightly on the mother" (F11); however, they also thought that men were "tertiary" (F10), often "overlooked" (F8) and "an afterthought" (F5) and that after the birth there was "nothing for the chap. Erm, and I felt I needed it far more than [wife] did" (F7). One father stated that this occurred throughout pregnancy and birth as antenatal preparation and midwifery appointments were aimed at mothers, even when the father was present.

7.3ii Tension between wanting help and being seen to take it.

Despite believing that men should be supported, the fathers conveyed that men "don't like to show weakness" (F11) or be seen to access help. One father explained that he would not have taken up any support offered at the time because "I'm a man" (F4), whilst another maintained that even when he was asked how he was feeling "you say you're fine, because there are two people who are far more important" (F10). He also suggested that an anonymous helpline might be useful so men could access support without being seen to do it. Some men commented that taking part in the study was useful because "talking about it helps" (F11), particularly "in a completely anonymous way" (F10). In fact, an opportunity to talk about their experience was often part of the motivation to participate. One father suggested that taking part had validated that his experience was difficult and upsetting as, "you're allowed to be emotional about it because someone understands that it does affect the partner as well" (F5).

Discussion

This study aimed to investigate what makes childbirth a traumatic experience for fathers, what impact this has and how men try to cope with the experience. The findings suggest that many factors, not all related to medical events, can contribute to a difficult experience and that the impact may be severe and enduring. A criticism of the research into post-traumatic stress after childbirth has been that it has not taken account of the diagnostic criterion regarding the stressor. In this research, all of the men met this criterion through their exposure to "threatened death, actual or threatened serious injury" (DSM-V, APA 2013). The IES (Horowitz, et al., 1979) is not diagnostic, therefore it is not possible to state whether any of the participants would meet the criteria for PTSD. However; regardless of symptomatology, all men reported distress that had subsequent impact on their lives.

The men's experience of the birth as "a rollercoaster" resonates with other findings on fathers' experiences of non-traumatic childbirth, such as Premberg, Carlsson, Hellström and Berg (2011: 848) who described fathers' experiences as "pendulating between agony and euphoria". However, the fathers in the current study did not experience euphoria at the end of the process; for them, layers of stress accumulated throughout labour and birth and, for some, after birth. This is an important distinction, particularly when considered within a stress and coping framework (e.g., Lazarus & Folkman, 1984). Stress occurs when "there are demands on a person which tax or exceed his adjustive resources" (Lazarus, 1976: 48) and is mediated by appraisals of threat. The accumulation of environmental stressors during the birth and the frequent shifting of events and emotional experiences contributed to fathers' threat appraisals – such as fear of death - and experience of stress. The longevity, for some men, of the emotional stress experienced placed enormous strain on the men's coping resources.

Men have been found to favour problem-focused coping strategies for managing stress, which usually rely on taking control and action (e.g. Ptacek, Smith & Dodge, 1994). Their frustration with lack of communication from staff and the search for information about what was happening reflect this. However, in most cases, their attempts to use these strategies seem to have been thwarted, leaving the fathers feeling out of control during the birth.

Several of the stressors that men described are interesting findings. The distortions of perception experienced by some fathers during the birth, which appears to be a new finding, could indicate peritraumatic dissociation, which includes feelings of unreality and distorted sense of time during the traumatic experience (e.g., Tichenor, Marmar, Weiss, Metzler & Ronfeldt, 1996). Olde et al. (2005) found perinatal dissociation could occur in women during childbirth and was an indicator of subsequent PTSD. It is not possible to infer from one study of this size but the experiences the men described indicate that further investigation of these phenomena in fathers may be warranted.

The isolation and abandonment described by the men is also of interest. Men can often feel excluded to some degree during childbirth (e.g., Chandler & Field, 1997; Longworth & Kingdon, 2009) but the present study suggests that this may be far more important than has perhaps been recognised. Experiences of abandonment intensified the fathers' distress and anxiety. This is a relatively unique finding in the literature with one other brief report on fathers of infants in neonatal intensive care mentioning this profound sense of abandonment (Koppel & Kaiser, 2001). The finding suggests a role for maternity services in providing additional support for fathers at these times.

This study found that birth experiences had a significant impact on the men's lives and functioning. Experiences of disconnection and preoccupation with the events are consistent with post-traumatic stress, as is avoidance, which was the primary coping

strategy adopted by most of the men. Ideas about masculinity seemed to influence the men's strategies for managing their distress. Pleck's (1995) gender-role strain paradigm states that in situations of conflict between expected masculine roles and the demands of other roles, dysfunction strain may occur. Conflict between the internal need to remain 'manly' and stoic in the face of the accumulation of stressors may have led to the men coping through avoidance; but this had significant consequences for some of them.

The idea of masculinity ideology is particularly pertinent to the men's perception that "nothing's actually happened to *me*" and the view that being affected by the emotional aspects of the experience was in some way fraudulent. This seems to have established how they would cope with the experience afterwards, leading to the avoidance strategies adopted. This is an important finding. White (2007) demonstrated that men tried to avoid showing their distress after the birth but what this study adds is that some men do not view what they have been through as something that should cause distress. They seem to invalidate their own experiences, which subsequently impacts on whether or not they access support. In spite of this, most of the men acknowledged that they were distressed and desired a resolution to the experience. Addis and Mahalik (2003) highlight that when problems are perceived to be unusual, or non-normative, the risk to self-esteem of seeking support is greater than if they are viewed as normative. This could explain why some of the men, though clearly distressed, were reluctant to acknowledge their difficulties to others or seek help, because they did not view their distress at the birth experience as 'normal'.

What seems poignant is that this dismissal of their experience and the coping strategies that the men employed are likely to extend, rather than resolve, their difficulties with the birth experience. Ehlers and Clark's (2000) cognitive model of PTSD posits the importance of integration of trauma memories, which strategies such as thought suppression and avoidance, as used by these fathers, prevents. Furthermore, the

tendency for men to avoid seeking help for either physical or mental health problems (e.g., Addis & Mahalik, 2003) is likely to prolong their distress. It may also increase the distress for partners, as several men acknowledged the negative impact of their feelings about the birth on their partners, which is consistent with the findings of Nicholls and Ayers' (2007) study with couples. It is, however, encouraging to note that almost all of the fathers felt that their relationships with their children were positive and had not been adversely affected by their experience of the birth.

Clinical implications

The findings have implications for maternity services and how they incorporate men within pregnancy, labour and childbirth. Within fifty years, men have moved from being total outsiders to the birth experience to a position of being almost mandated to be present. This has been a seismic shift, yet the culture of maternity care has not adapted to this change. The view expressed by men that "nothing's actually happened to *me*" is perhaps mirrored by the way maternity services treat them; paying relatively little attention to fathers, other than as a supporter for the mother. Men are exposed to everything that occurs during labour and birth that it seems reasonable to suggest that they should be treated as patients in their own right.

Men's desire for preparation suggests that services need to acknowledge the different needs of fathers and mothers in pregnancy and birth. The study also highlights the importance of care for both parents, particularly during complicated births. Men desire communication and information to help them contextualise their experiences. The abandonment felt by fathers during times of distress suggests a lack of care. Fathers want to be near their families after distressing births (Johansson, Hildingsson & Fenwick, 2013) and report more positive experiences when they are able to remain in hospital (Hildingsson, Thomas, Olofsson & Nystedt, 2009).

The effect of cumulative stressors on the men's experience suggest that it may be difficult for health professionals to pick up on fathers' distress, as what staff might view as minor incidents could be having a far greater impact on the men within the wider context of the birth experience. In addition, men's reluctance to show what they perceive as weakness in the situation means that it is unlikely they will ask for support. Given these issues, it may be that any screening, support or intervention should be offered universally, to reduce the impact of any perceived stigma in accepting help.

This research suggests that some men may find attendance at childbirth to be a traumatic event and go on to experience subsequent distress, including symptoms of post-traumatic stress. This is of relevance to clinical psychologists when considering the impact of birth experiences on the mental health and emotional well-being of men themselves, but also the indirect effects this may have on the man's partner and baby, both in infancy and later development. Fathers' mental health has been shown to have an impact on the development of behavioural difficulties in children (Ramchandani & Psychogiou, 2009). It may be particularly important during infancy and the development of attachments.

Limitations

Most fathers described some form of obstetric complication during the birth. This likely reflects the recruitment strategy of accessing men via trauma-related and fathers' websites. It may mean that fathers who have found birth traumatic for reasons other than obstetric complications may have been less likely to find and take part in the study. Furthermore, the clear message that men are very reluctant to either acknowledge their difficulties or access support, and the dominant coping strategy of avoidance indicate that there are likely to be men whose experiences would be important to the study but who would not come forward to participate.

Future research

Longitudinal studies with fathers to investigate the risk factors for developing mental health difficulties such as PTSD following child birth, the prevalence and course of the difficulties are required. As highlighted by Ayers, et al. (2008), studies that include full diagnostic assessment of PTSD are required. Given that almost all of the men in this study experienced objectively complicated births, further research into men's experiences of non-routine childbirth would be useful and may help to clarify the factors that contribute to subjective distress. Future research could include intervention studies into how information is provided to fathers and how they are prepared for birth and supported afterwards. Additional research into the nature of couple's experiences of a traumatic birth may also help to elucidate interactions between how couples cope with these experiences.

Conclusion

This study adds to current literature that suggests being present at childbirth can be an extremely distressing experience for men and one which may induce symptoms of post-traumatic stress, which can be severe and enduring. It suggests that it is essential for maternity services to attend to the needs of fathers in their own right before, during and after childbirth. Masculinity ideology may act as a barrier to men accessing help; therefore support structures should be in place as a matter of course for all fathers.

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

References

Addis, M.E. & Mahalik, J.R. (2003). Men, masculinity and the contexts of help-seeking. *American Psychologist, 58*(1), 5-14. doi: 10.1037/0003-066X.58.1.5

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Andersen, L.B., Melvaer, L.B., Videbech, P., Lamont, R.F. & Joergensen, J.S. (2012) Risk factors for developing post-traumatic stress disorder following childbirth: a systematic review. *Acta Obstetricia et Gynecologica Scandinavica, 91*, 1261-1272. doi: 10.1111/j.1600-0412.2012.01476x

Ayers, S., Joseph, S., McKenzie-McHarg, K., Slade, P. & Wijma, K. (2008) Post-traumatic stress disorder following childbirth: current issues and recommendations for future research. *Journal of Psychosomatic Obstetrics & Gynecology, 29*(4), 240-250. doi: 10.1080/01674820802034631

Ayers, S., Wright, D. B., &Wells, N. (2007). Brief report: symptoms of post-traumatic stress disorder in couples after birth: association with the couple's relationship and parent-baby bond. *Journal of Reproductive and Infant Psychology, 25*(1), 40–50.

Beck., C.T. (2004). Birth trauma – in the eye of the beholder. *Nursing Research, 53*(1), 28-35.

Bradley, R. & Slade, P. (2011) A review of mental health problems in fathers following the birth of a child. *Journal of Reproductive and Infant Psychology 29*(1), 19-42. Doi: 10.1080/02646838.2010.513047

Bradley, R., Slade, P., & Leviston, A. (2008). Low rates of PTSD in men attending childbirth: A preliminary study. *British Journal of Clinical Psychology, 47*(3), 295-302.

Chandler, S., & Field, P. A. (1997). Becoming a father - first-time fathers' experience of labor and delivery. *Journal of Nurse-Midwifery, 42*(1), 17-24.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour research and therapy*, *38*(4), 319-345.

Garthus-Niegel, S., Von Soest, T., Vollrath, M. E., & Eberhard-Gran, M. (2013). The impact of subjective birth experiences on post-traumatic stress symptoms: A longitudinal study. *Archives of Women's Mental Health, 16*(1), 1-10.

Hildingsson, I., Thomas, J., Olofsson, R., & Nystedt, A. (2009). Still behind the glass wall? Swedish fathers' satisfaction with postnatal care. *Journal Of Obstetric, Gynecologic, & Neonatal Nursing: Clinical Scholarship For The Care Of Women, Childbearing Families, & Newborns*, *38*(3), 280-289. doi:10.1111/j.1552-6909.2009.01024.x

Horowitz, M. J., Wilner, N. N., & Alvarez, W. W. (1979). Impact of events scale: A measure of subjective stress. *Psychosomatic Medicine, 41*(3), 209-218.

Iles, J., Slade, P. & Spiby, H. (2011). Posttraumatic stress symptoms and postpartum depression in couples after childbirth: The role of partner support and attachment. *Journal of Anxiety Disorders, 25*, 520-530.

Johansson, M., Hildingsson, I., & Fenwick, J. (2013). Fathers want to stay close to their partner and new baby in the early postnatal period: The importance of being able to room in after a surgical birth. *Sexual & Reproductive Healthcare*, *4*(1), 35-36.

Kiernan, K. & Smith, K. (2003) Unmarried parenthood: new insights from the Millennium Cohort Study. *Population Trends*, *114*: 26-33. Retrieved from

http://www.ons.gov.uk/ons/rel/population-trends-rd/population-trends/no--114--winter-2003/population-trends.pdf

King, N. (2004). Using templates in the thematic analysis of texts. In C. Cassell & G. Symon (Eds.) *Essential guide to qualitative methods in organizational research.* (pp256-270). London: Sage

King, N. (2008) Professor Nigel King on Template Analysis [Video file] Retrieved from http://onlineqda.hud.ac.uk/_REQUALLO/FR/Template_Analysis/Index.php

Koppel, G. T., & Kaiser, D. (2001). Fathers at the end of their rope: A brief report on fathers abandoned in the perinatal situation. *Journal of Reproductive and Infant Psychology, 19*(3), 249-251.

Kunjappy-Clifton, A. (2008). And father came too... A study exploring the role of first time fathers during the birth process and to explore the meaning of the experience for these men: Part two. *MIDIRS Midwifery Digest, 18*(1), 57-66.

Lazarus, R. & Folkman, S. (1984) *Stress, appraisal and coping*. New York: Springer.

Lazarus, R.S. (1976) *Patterns of adjustment (3rd Edition.* Tokyo: McGraw-Hill Kogakusha Ltd.

Longworth, H. L., & Kingdon, C. K. (2011). Fathers in the birth room: What are they expecting and experiencing? A phenomenological study. *Midwifery, 27*(5), 588-594.

Neal, L.A., Busuttil, W., Rollins, J., Herepath, R., Strike, P. & Turnbull, G. (1994) Convergent validity of measures of post-traumatic stress disorder in a mixed military and civilian population. *Journal of Traumatic Stress, 7*(3), 447-455. doi:10.1007/BF02102789

Nicholls, K., & Ayers, S. (2007). Childbirth-related post-traumatic stress disorder in couples: a qualitative study. *British Journal of Health Psychology, 21*(4), 491-509.

Olde, E., van der Hart, O., Kleber, R. J., van Son, M. M., Wijnen, H. A., & Pop, V. M. (2005). Peritraumatic dissociation and emotions as predictors of PTSD symptoms following childbirth. *Journal Of Trauma & Dissociation*, *6*(3), 125-142. doi:10.1300/J229v06n03_06

Parfitt, Y.M. & Ayers, S. (2009). The effect of post-natal symptoms of post-traumatic stress and depression on the couple's relationship and parent-baby bond. *Journal of Reproductive and Infant Psychology*, *27*(2), 127-142.

Pleck, J.H. (1995). The gender role strain paradigm: An update. In R.F. Levant and W.S. Pollack (Eds.), *A new psychology of men* (pp11-32). New York: Basic Books.

Premberg, A., Carlsson, G., Hellstrom, A., & Berg, M. (2011). First-time fathers' experiences of childbirth-A phenomenological study. *Midwifery*, *27*(6), 848-853.

Ptacek, J.T., Smith, R.E. & Dodge, K.L. (1994) Gender differences in coping with stress: when stressor and appraisals do not differ. *Personality and Social Psychology Bulletin, 20*(4), 421-430. doi: 10.1177/0146167294204009

Ramchandani, P. & Psychogiou, L. (2009) Paternal psychiatric disorders and children's psychosocial development. *Lancet, 373*: 646-653. doi: 10.1016.S0140-6736(09)60238-5

Sundin, E. C. & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric properties. *British Journal Of Psychiatry*, *180*(3), 205-209. doi:10.1192/bjp.180.3.205

Tichenor, V., Marmar, C., Weiss, D., Metzler, T., & Ronfeldt, H. (1996). The relationship of peritraumatic dissociation and posttraumatic stress: findings in female Vietnam theater veterans. *Journal Of Consulting And Clinical Psychology*, *64*(5), 1054-1059.

White, G. (2007). You cope by breaking down in private: fathers and PTSD following childbirth. *British Journal of Midwifery, 15(1)*: 39-45

Wynter, K., Rowe, H., & Fisher, J. (2013). Common mental disorders in women and men in the first six months after the birth of their first infant: A community study in Victoria, Australia. *Journal Of Affective Disorders*, *151*(3), 980-985. doi:10.1016/j.jad.2013.08.021

Appendices

Appendix A.
International Journal of Nursing Studies – Author Guidelines

Aims and scope

[Copied from http://www.journals.elsevier.com/international-journal-of-nursing-studies/]

The *International Journal of Nursing Studies* (IJNS) provides a forum for original research and scholarship about **health care** delivery, organisation, management, workforce, policy and research methods relevant to **nursing**, **midwifery** and other health related professions. The *IJNS* aims to support evidence informed policy and practice by publishing research, systematic and other scholarly reviews, critical discussion, and commentary of the highest standard.
The journal particularly welcomes studies that aim to evaluate and understand complex health care interventions and health policies and which employ the most rigorous designs and methods appropriate for the research question of interest. The journal also seeks to advance the quality of research by publishing methodological papers introducing or elaborating on analytic techniques, measures, and research methods.

Author guidelines

[Applicable guidance copied from http://www.elsevier.com/journals/international-journal-of-nursing-studies/0020-7489/guide-for-authors]

The IJNS publishes original research, reviews, and discussion papers. In addition we publish editorials and letters. Where a case is made we will also publish protocols of trials which meet our general criteria for interest and significance.

Reviews and Discussion Papers — 2,000–7,000 words

• Reviews, including:
- systematic reviews, which address focussed practice questions;
- literature reviews (scoping reviews, narrative reviews), which provide a thorough analysis of the literature on a broad topic;
- policy reviews, i.e. reviews of published literature and policy documents which inform nursing practice, the organisation of nursing services, or the education and preparation of nurses and/or midwives).
• Discussion Papers, i.e. scholarly articles of a debating or discursive nature.

There are no strict requirements on reference formatting. References can be in any style or format as long as the style is consistent and complete. Author(s) name(s), journal title / book title, article title, year of publication, volume and issue / book chapter and the pagination must be present. The reference style required by the journal will be applied to the published version by Elsevier.

Formatting requirements:

There are no strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract,

Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions. You may wish to consult the requirements for standard submissions in advance as you will need to ensure that your manuscript adheres to these at a later stage.

GENERAL GUIDANCE FOR ALL SUBMISSIONS

Abstract — Abstracts should be less than 400words, and should not include references or abbreviations. Abstracts of research papers must be structured and should adopt the headings suggested by the relevant reporting guidelines (see below). In general they should include the following: Background; Objectives; Design; Settings (do not specify actual centres, but give the number and types of centre and geographical location if important); Participants (details of how selected, inclusion and exclusion criteria, numbers entering and leaving the study, relevant clinical and demographic characteristics); Methods; Results, report main outcome(s)/findings including (where relevant) levels of statistical significance and confidence intervals; and Conclusions, which should relate to study aims and hypotheses. Abstracts for reviews should provide a summary under the following headings, where possible: Objectives, Design, Data sources, Review methods, Results, Conclusions. Abstracts for book review articles and discussion papers should provide a concise summary of the line of argument pursued and conclusions.

Key Words — Provide between four and ten key words in alphabetical order, which accurately identify the paper's subject, purpose, method and focus. Use the Medical Subject Headings (MeSH®) thesaurus or Cumulative Index to Nursing and Allied Health (CINAHL) headings where possible (see http://www.nlm.nih.gov/mesh/meshhome.html).

Abbreviations — Avoid the use of abbreviations unless they are likely to be widely recognised. In particular you should avoid abbreviating key concepts in your paper where readers might not already be familiar with the abbreviation. Any abbreviations which the authors intend to use should be written out in full and followed by the letters in brackets the first time they appear, thereafter only the letters without brackets should be used.

Table and figures — There should be no more than five tables and figures in total and included in a separate file. All tables and figures should be clearly labelled. If your manuscript includes more than 5 tables in total, or for very large tables, these can be submitted as Supplementary Data and will be included as such in the online version of your article.

Appendices — Ordinarily there should be no appendices although in the case of papers reporting tool development or the use of novel questionnaires authors must include a copy of the tool as an appendix unless all items appear in a table in the text.

Informed consent — Where applicable authors should confirm that informed consent was obtained from human subjects and that ethical clearance was obtained from the appropriate authority.

Permissions - Permission to reproduce previously published material must be

obtained in writing from the copyright holder (usually the publisher) and acknowledged in the manuscript.

Word limits - Our experience suggests that all things being equal, readers find shorter papers more useful than longer ones. Given this, and competition for space in the Journal, shorter papers of between 2,000 and 3,500 words are preferred. However, full papers may be up to 7,000 words in length, plus tables, figures, and references. Ordinarily there should be no appendices although in the case of papers reporting tool development or the use of novel questionnaires it is usual to include a copy of the tool as an appendix

MANUSCRIPT LAYOUT

Title

The title should be in the format 'Topic / question: design/type of paper' and identify the population / care setting studied.(e.g. The effectiveness of telephone support for adolescents with insulin dependent diabetes: controlled before and after study).

Required for all papers (with the exception of Letters) is a clear summary of the 'Contribution of the Paper'. This should take the form of a clear summary of "What is already known about the topic?' and 'What this paper adds', identifying existing research knowledge relating to the specific research question / topic and a summary of the new knowledge added by this study. Under each of these headings, please provide clear OUTCOME statements in the form of two or three bullet points for each. Do NOT give process statements of what the paper does. eg. This review demonstrates that nurse-led intermediate care reduces hospital stay but increases total inpatient stay (outcome) NOT This review considers the impact of nurse-led intermediate care on acute stay and total inpatient stay (process).

References

The reference style required by the journal will be applied to the published version by Elsevier but if you wish to format references yourself they should be arranged in a name/date citation style and should be consistent throughout. Avoid citation of personal communications or unpublished material. Citations to material in press (i.e accepted for publication) is acceptable. Citation of material currently under consideration elsewhere (e.g. "under review" or "submitted") is not.

All publications cited in the text should be presented in a list of references at the end of the manuscript. In the text refer to the author's name (without initials) and year of publication (e.g. "Since Peterson (1993) has shown that?" or "This finding is supported by results obtained later (Kramer, 1994)"). For three or more authors use the first author followed by "et al.", in the text. For one or more references in the text to support a single idea, the names should be organized alphabetically (Bryman, 2004, Lincoln and Guba, 2000, Onwuegbuzie and Leech, 2005). No more than three references should be used to support a single idea

Appendix B.
CASP Qualitative Research Checklist

©Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist 31.05.13

[copied from:
http://media.wix.com/ugd/dded87_951541699e9edc71ce66c9bac4734c69.pdf]

10 questions to help you make sense of qualitative research
How to use this appraisal tool
Three broad issues need to be considered when appraising the report of a qualitative research:
• Are the results of the review valid?
• What are the results?
• Will the results help locally?

The 10 questions on the following pages are designed to help you think about these issues systematically.

The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

Screening Questions

1. Was there a clear statement of the aims of the research? □Yes □Can't tell □No

HINT: Consider
• What was the goal of the research?
• Why it was thought important?
• Its relevance

2. Is a qualitative methodology appropriate? □Yes □Can't tell □No

HINT: Consider
• If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
• Is qualitative research the right methodology for addressing the research goal?
Is it worth continuing?

Detailed questions

3. Was the research design appropriate to □Yes □Can't tell □ No

address the aims of the research?
HINT: Consider
• If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research? □Yes □Can't tell □No
HINT:Consider
• If the researcher has explained how the participants were selected
• If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
• If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue? □Yes □Can't tell □No
HINT: Consider
• If the setting for data collection was justified
• If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
• If the researcher has justified the methods chosen
• If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
• If methods were modified during the study. If so, has the researcher explained how and why?
• If the form of data is clear (e.g. tape recordings, video material, notes etc)
• If the researcher has discussed saturation of data

6. Has the relationship between researcher and participants been adequately considered? □Yes □Can't tell □No
HINT: Consider
• If the researcher critically examined their own role, potential bias and influence during
(a) Formulation of the research questions
(b) Data collection, including sample recruitment and choice of location
• How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration? □Yes □Can't tell □No
HINT: Consider
• If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
• If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they

have handled the effects of the study on the participants during and after the study)
• If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous? □Yes □Can't tell □No
HINT: Consider
• If there is an in-depth description of the analysis process
• If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
• Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
• If sufficient data are presented to support the findings
• To what extent contradictory data are taken into account
• Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings? □Yes □Can't tell □No
HINT: Consider
• If the findings are explicit
• If there is adequate discussion of the evidence both for and against the researchers arguments
• If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
• If the findings are discussed in relation to the original research question

10. How valuable is the research?
HINT: Consider
• If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
• If they identify new areas where research is necessary
• If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Appendix C
Database search terms

CINAHL

1. Father* OR (MH Fathers)
2. *birth OR (MH Childbirth)
3. Qualitative OR (MH qualitative studies) OR experience
4. 1 AND 2 AND 3

300 results

Medline

1. exp Fathers/ or exp Father-child relations/
2. *birth/
3. Qualitative Research/ or qualitative.mp.
4. experience*.mp.
5. 3 OR 4
6. 1 AND 2 AND 5

23 results

PsycINFO

1. Father* OR DE Fathers
2. *birth OR DE Birth
3. Qualitative* OR DE Qualitative Research OR DE Content Analysis OR DE Grounded Theory OR DE Interviews OR experience*
4. 1 AND 2 AND 3

736 results

Scopus

1. Father*
2. *birth
3. Qualitative*
4. Qualitative research
5. Experience*
6. 3 OR 4 OR 5
7. 1 AND 2 AND 6

874 results

Web of Science

1. Father*
2. Father-child relations
3. 1 OR 2
4. *birth
5. Qualitative research
6. Experience*
7. 5 OR 6
8. 3 AND 4 AND 7

1131 results

Total results before screening: 3064

Appendix D.

Journal of Clinical Psychology in Medical Settings

Aims and Scope

Journal of Clinical Psychology in Medical Settings is an international forum for the publication of peer-reviewed original papers related to all areas of the science and practice of psychologists in medical settings. Manuscripts are chosen that have a broad appeal across psychology as well as other health care disciplines, reflecting varying backgrounds, interests, and specializations. The journal publishes original research, treatment outcome trials, meta-analyses, literature reviews, conceptual papers, brief scientific reports, and scholarly case studies. Papers accepted address clinical matters in medical settings; integrated care; health disparities; education and training of the future psychology workforce; interdisciplinary collaboration, training, and professionalism; licensing, credentialing, and privileging in hospital practice; research and practice ethics; professional development of psychologists in academic health centers; professional practice matters in medical settings; and cultural, economic, political, regulatory, and systems factors in health care. In summary, the journal provides a forum for papers predicted to have significant theoretical or practical importance for the application of psychology in medical settings.

Instructions for Authors

Journal of Clinical Psychology in Medical Settings

(taken from: http://www.tandfonline.com/action/authorSubmission?journalCode=uqrp20&page=instructions)

(Note: No specified word limit for manuscripts)

General

In general, the journal follows the recommendations of the 2010 Publication Manual of the American Psychological Association (Sixth Edition), and it is suggested that contributors refer to this publication.

Manuscript Style

The suggested running head should be less than 80 characters (including spaces) and should comprise the article title or an abbreviated version thereof. For office purposes, the title page should include the complete mailing address, telephone number, and e-mail address of the one author designated to review proofs.

Abstract

An abstract is to be provided, preferably no longer than 150 words.

Key Words

A list of 4–5 key words is to be provided directly below the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

References

List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. References should include (in this order):

last names and initials of all authors,

year published

title of article

name of publication

volume number

and inclusive pages

The style and punctuation of the references should conform to strict APA style and follow guidelines of the Publication Manual of the American Psychological Association, Sixth Edition – illustrated by the following examples:

Journal Article

Burns, J. W., & Katkin, E. S. (1993). Psychological, situational, and gender predictors of cardiovascular reactivity to stress: A multivariate approach. *Journal of Behavioral Medicine, 16,* 445−465.

Book

Ray, R. (2006): *Chronic Pain and Family: A Clinical Perspective.* New York: Springer.

Contribution to a Book

Bleiberg, J., Ciulla, R., & Katz, B. L. (1991). Psychological components of rehabilitation programs for brain−injured and spinal−cord−injured patients. In J. J. Sweet, R. H. Rozensky, & S. M. Tovian (Eds.), *Handbook of clinical psychology in medical settings* (pp. 375−400). New York: Plenum Press.

Footnotes

Footnotes should be avoided. When their use is absolutely necessary, footnotes should be numbered consecutively using Arabic numerals and should be typed at the bottom of the page to which they refer. Place a line above the footnote, so that it is set off from the text. Use the appropriate superscript numeral for citation in the text.

Illustration Style

Illustrations (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals. The captions for illustrations should be typed on a separate page.

Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table should be typed on a separate page. Center the title above the table, and type explanatory footnotes (indicated by superscript lowercase letters) below the table.

Informed consent

For studies with human subjects, please include the following statement before the References section: “All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.”

Animal and Human Rights

Human and Animal Rights: Manuscripts containing the results of experimental studies on human participants must disclose in the Methods section whether informed consent was obtained from patients in the study after the nature of the procedure had been fully explained to them. If informed consent was waived by the institutional review board (IRB) for a study, that should be so stated. In addition, a statement affirming approval of the IRB should be included, if approved. The patient's right to privacy should not be infringed.

Appendix E.
Research Advertisement

How can we help fathers who experienced their baby's birth as traumatic?
Research project

Fathers wanted to take part in research

I am training to work as a clinical psychologist for the NHS . I am carrying out a study as part of a doctoral degree to explore the experiences of fathers who have had difficulties after attending the birth of their child.

Experiencing or witnessing a traumatic birth can be extremely distressing for both parents; however, most research has focused on the impact on women. We think it is important to learn more about the impact these experiences have on men.

The aim of the study is to understand what makes the experience traumatic and how fathers try to cope with the experience.

We hope that this will help services provide better support for fathers in the future.

What does it involve?
The study involves completing a brief questionnaire online and taking part in a confidential telephone interview. Names are not needed.

To take part in the study you will need to:

- Be 16 years or older
- Have attended the birth of your child and found the experience traumatic
- Be willing to complete the questionnaire and a telephone interview

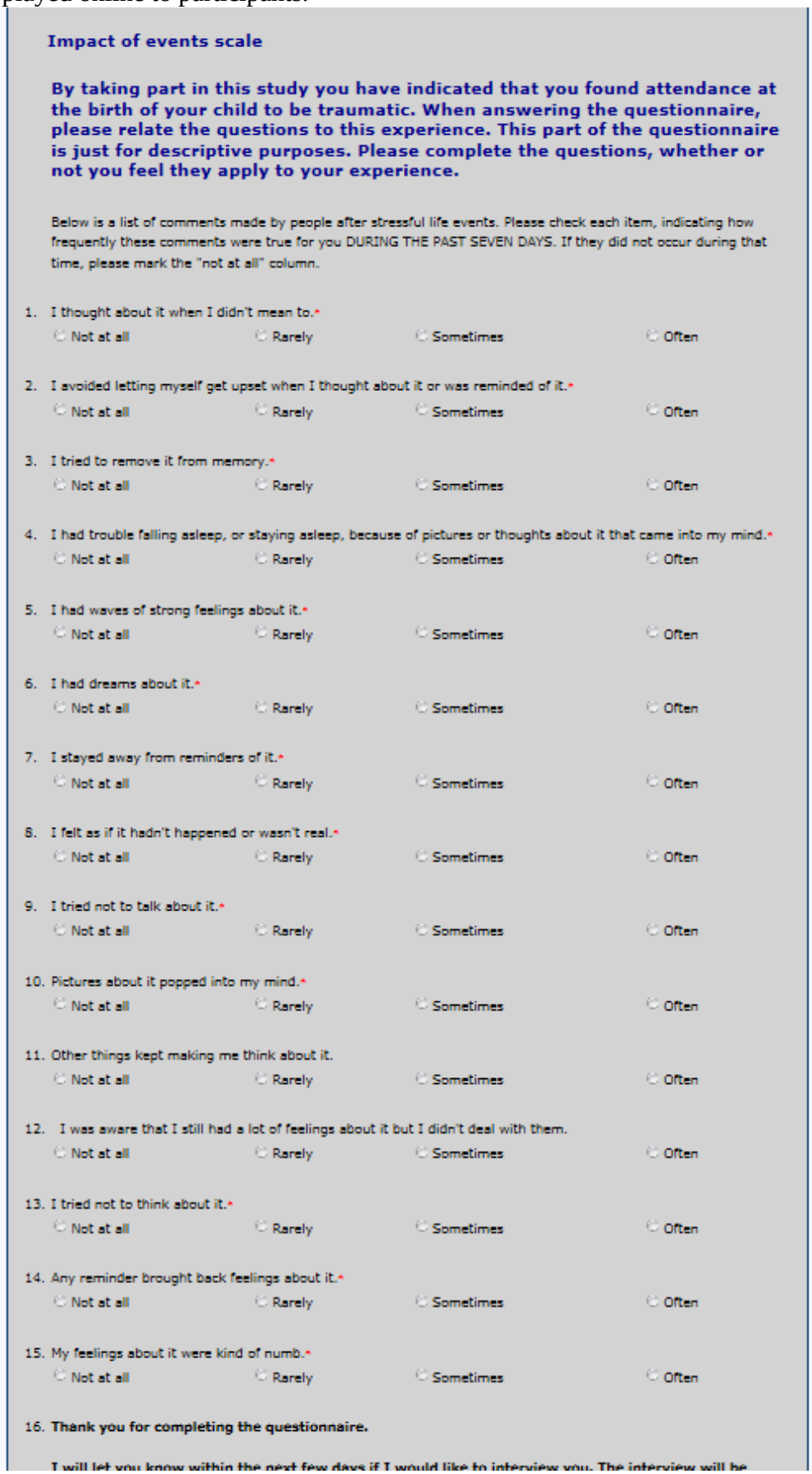
If you have experienced the death of your partner or child during childbirth, or your baby has long-term health problems, the study would not be appropriate for you. However, if you are having difficulties with these experiences, support can be accessed via your GP. The Birth Trauma Association (www.bta.org.uk) also offers support and advice for parents.

How can I find out more?
If you are interested in the study, please email me: j.etheridge@liverpool.ac.uk and I will send you more information.

This study has been approved by the University of Liverpool
Research Ethics Committee

Appendix F.
Impact of Event Scale

As displayed online to participants.



Impact of events scale

By taking part in this study you have indicated that you found attendance at the birth of your child to be traumatic. When answering the questionnaire, please relate the questions to this experience. This part of the questionnaire is just for descriptive purposes. Please complete the questions, whether or not you feel they apply to your experience.

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please mark the "not at all" column.

1. I thought about it when I didn't mean to.*
   ○ Not at all ○ Rarely ○ Sometimes ○ Often
2. I avoided letting myself get upset when I thought about it or was reminded of it.*
   ○ Not at all ○ Rarely ○ Sometimes ○ Often
3. I tried to remove it from memory.*
   ○ Not at all ○ Rarely ○ Sometimes ○ Often
4. I had trouble falling asleep, or staying asleep, because of pictures or thoughts about it that came into my mind.*
   ○ Not at all ○ Rarely ○ Sometimes ○ Often
5. I had waves of strong feelings about it.*
   ○ Not at all ○ Rarely ○ Sometimes ○ Often
6. I had dreams about it.*
   ○ Not at all ○ Rarely ○ Sometimes ○ Often
7. I stayed away from reminders of it.*
   ○ Not at all ○ Rarely ○ Sometimes ○ Often
8. I felt as if it hadn't happened or wasn't real.*
   ○ Not at all ○ Rarely ○ Sometimes ○ Often
9. I tried not to talk about it.*
   ○ Not at all ○ Rarely ○ Sometimes ○ Often
10. Pictures about it popped into my mind.*
    ○ Not at all ○ Rarely ○ Sometimes ○ Often
11. Other things kept making me think about it.
    ○ Not at all ○ Rarely ○ Sometimes ○ Often
12. I was aware that I still had a lot of feelings about it but I didn't deal with them.
    ○ Not at all ○ Rarely ○ Sometimes ○ Often
13. I tried not to think about it.*
    ○ Not at all ○ Rarely ○ Sometimes ○ Often
14. Any reminder brought back feelings about it.*
    ○ Not at all ○ Rarely ○ Sometimes ○ Often
15. My feelings about it were kind of numb.*
    ○ Not at all ○ Rarely ○ Sometimes ○ Often
16. **Thank you for completing the questionnaire.**

I will let you know within the next few days if I would like to interview you. The interview will be

Appendix G
Confirmation of Ethical Approval

Dear Professor Slade

I am pleased to inform you that the Sub-Committee has approved your application for ethical approval for your study. Details and conditions of the approval can be found below.

In order that this approval is valid, please ensure that the final version of your application, with all supporting documentation is emailed to the Research Governance Officer, Legal, Risk and Compliance, at ethics@liverpool.ac.uk within 5 days of receipt of this email.

Ref:	RETH000644
Sub-Committee:	Non-Invasive Procedures
Review type:	Chair's Action
PI:	Professor Pauline Slade
School:	IPHS
Title:	Fathers' experiences of trauma following attendance at childbirth
First Reviewer:	Dr John Downes
Second Reviewer:	n/a
Third Reviewer (if applicable):	n/a
Date of initial review:	1/10/13
Date of Approval:	1/10/13

The application was APPROVED subject to the following conditions:

Conditions

1	Mandatory	M: All serious adverse events must be reported to the Sub-Committee within 24 hours of their occurrence, via the Research Governance Officer (ethics@liv.ac.uk).

This approval applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, the Sub-Committee should be notified. If it is proposed to make an amendment to the research, you should notify the Sub-Committee by following the Notice of Amendment procedure outlined at http://www.liv.ac.uk/media/livacuk/researchethics/notice%20of%20amendment.doc. If the named PI / Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore please contact the RGO at ethics@liverpool.ac.uk in order to notify them of a change in PI / Supervisor.

Best Wishes

Sarah

Mrs Sarah Wright
Research Governance Officer
Legal, Risk and Compliance
University of Liverpool
The Waterhouse Buildings, Block C
Liverpool
L69 3GL

Appendix H.
Wording of initial email following email of interest from participants

Dear (name),

Thanks for getting in touch about the research being carried out by the University of Liverpool and the Birth Trauma Association. I hope you'll find it interesting and useful.

I've attached an information sheet that gives further details about the project to help you decide if it's something you'd like to take part in. This is also available if you follow the link in the box below.

The study involves a very short on-line questionnaire to check you're able to take part in the study, then a telephone interview at a later date to talk about your experiences of being at the birth of your child.

What do I need to do if I want to take part?

- Please click on this link http://survey.liv.ac.uk/fathers.
  This will direct you to: - information about the study
  - confirm your consent to take part
  - a brief questionnaire about your experiences
- The questionnaire will ask you for a code so that you can answer anonymously. Your code is **[insert code here].**
  Please make a note of the code as you'll need it to complete the questionnaire.
- You'll also be asked for your contact details so that you can take part in the telephone interview.

If you have any further questions, please get in touch on this email address or on this number: **0151 794 5530** and I'll get back to you as quickly as I can.

Thanks again for getting in touch.

Best wishes,

Jody

Jody Etheridge
Clinical Psychologist in training
Division of Clinical Psychology
Whelan Building, The Quadrangle,
Brownlow Hill,
Liverpool.
L69 3GB

Tel: 0151 794 5530

Appendix I.
Participant Information Sheet

Fathers' experiences of trauma following attendance at childbirth

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. Please also feel free to discuss this with your friends, relatives and GP if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

What is the purpose of the study?

The aim of this study is to explore the experiences of fathers who have found attendance at childbirth to be traumatic.

The study will investigate:

1) what causes fathers to experience a birth as traumatic;
2) how fathers respond to a traumatic birth;
3) how they try to cope;
4) what impact the trauma has (for instance, on their relationship with their partner);
5) what things might help fathers before or after the birth

Why have I been chosen to take part?

You have been invited to take part because you have indicated that you found being at the birth of your child traumatic.

Do I have to take part?

No. Taking part in the research is entirely voluntary. You are free to decide not to take part at *any time* during the research and you do not have to give any reason.

What will happen if I decide to take part?

If you decide to take part, you will be asked to complete an on-line questionnaire about any difficulties you've had after attending the birth of your child. You may also be asked to take part in a telephone interview. The interview will be about your experiences related to the birth of your child and the difficulties you have experienced.

The interview will be carried out by Jody Etheridge, Trainee Clinical Psychologist and will last up to one hour.

The interview will be recorded so that the researchers can listen to and analyse what has been said.

Are there any risks in taking part?

Most people find talking through difficult experiences helpful. However this can temporarily highlight any feelings of distress. The interview will all be at your own pace and under your own control and you are of course free to discontinue at any point.

What happens if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please contact Jody Etheridge (j.etheridge@liverpool.ac.uk) or Professor Pauline Slade (0151 794 5485/ ps1ps@liverpool.ac.uk) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer on 0151 794 8290 (ethics@liv.ac.uk). When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

Will my participation be kept confidential?

Yes.

Will my taking part be covered by an insurance scheme?

The study has been approved by and has insurance from the University of Liverpool.

Who can I contact if I have further questions?

Jody Etheridge (j.etheridge@liverpool.ac.uk)

Clinical Psychology Department
University of Liverpool
The Whelan Building
Brownlow Hill
Liverpool
L69 3GB
United Kingdom

Support for people affected by birth trauma:

During the course of the research, you may feel you need more support to help you cope with your experiences.

Help is available through contacting your GP.

The Birth Trauma Association (www.birthtraumaassociation.org.uk) also provide support for men and women who have been affected by difficulties related to childbirth.

Appendix J.
Consent and Screening Questionnaire

Consent

Please complete the questions on this page if you wish to take part in the study.

1. **Please enter the ID code you were sent by email:**
   (If you have forgotten your code, please email me at j.etheridge@liverpool.ac.uk and I'll send you a new one)*

2. **I confirm that I have read and understood the information about the study "Fathers' experiences of trauma following childbirth".***
   ○ Yes ○ No

3. **I understand that my participation in the study is voluntary and that I may withdraw at any time, without having to give a reason.***
   ○ Yes ○ No

4. **I understand that, after completing this questionnaire, I may be asked to take part in a telephone interview***
   ○ Yes ○ No

5. **I consent to taking part in this study***
   ○ Yes ○ No

To check the study is appropriate for you to take part in, please answer the following questions.

6. **I confirm that I am 16 years of age or older.***
   ○ Yes ○ No

7. **I am currently living with the mother of my child.***
   ○ Yes ○ No

8. **My child was born within the last ten years.***
   ○ Yes ○ No

9. **If your child spent time in neonatal intensive care when they were born, this was for less than 7 days.***
   If your baby didn't need any special care, please answer "yes".
   ○ Yes ○ No

10. **Both my partner and baby survived child birth.***
    ○ Yes ○ No

11. **At some point during the child birth I experienced feelings of intense fear, helplessness or horror.***
    ○ Yes ○ No

Appendix K.
Reflexive account

Given that some level of interpretation is almost inevitable when analysing qualitative work I endeavoured to bear in mind my responses to the interviews conducted and how this might affect my interpretation of the data. Brief notes were kept after each interview as a reminder of my personal responses. I was also mindful that the motivation to carry out this research came from knowledge of the experiences of one of my friends. I endeavoured to "bracket" this knowledge throughout the data collection.

I was struck in the first interview by the level of impact that the childbirth experience had had on the father I spoke to. He spoke for almost 40 minutes on the first question and, when I reflected back, I found it difficult to be in the position of researcher rather than clinician. My instinct was of wanting to find some help for this man; which was something I was very mindful of. Some participant narratives struck me as very poignant and I was aware of feeling empathy for the men. In some ways, I used this, not to drive the analysis, but in terms of the drive to write a good paper that might inform practice in some way and influence other men's experiences.

My initial feelings of unease with conducting research interviews, rather than clinical work with the men involved was later replaced with a sense of privilege and, in some ways, gladness that the research had, for some, given them an opportunity to speak about their experiences. However, this may also have influenced my analysis and write up, particularly with regard to the clinical implications of the work, and I re-checked this as I reviewed my work.

Appendix L.
Template Analysis

Template analysis is a form of thematic analysis. King (2004) describes it lying somewhere between bottom-up approaches, such as Grounded Theory (Glaser & Strauss, 1967), top-down approaches, such as Framework analysis. Template analysis is described as a technique rather than a distinct methodology and King states that it can be employed from a range of epistemological stances, including phenomenology.

King (2004) suggests that template analysis is particularly useful for applied research, where there a specific goals or questions that the research wants to address in the findings. In this way, it is less exploratory and interpretative than Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009). However, when approached from a phenomenological perspective, King states that IPA and Template Analysis may not be dissimilar. The main differences between them when adopting a phenomenological perspective are "the use of a priori codes in template analysis, and the balance between within and across case analysis. IPA tends to analyse individual cases in greater depth before attempting any integration of a full set of cases." (King, 2004: 257).

King (2004) suggest that, although template analysis can be used for any number of cases, including single case studies, it is most commonly used with sample sizes of between10 and 20 participants.

References

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. London: Weidenfield & Nicolson.

King, N. (2004). Using templates in the thematic analysis of texts. In C. Cassell & G. Symon (Eds.) *Essential guide to qualitative methods in organizational research.* (pp256-270). London: Sage

Smith, J.A., Flowers, P. & Larkin, M. (2009) *Interpretative Phenomenological Analysis: theory, method and research.* London: Sage

Appendix M.
Example of initial coding of transcript

401 402 403 404 405 406 407	R	erm and they just, they just said "oh well we can't we can't move you, you've got to do it yourself you're just going to have to do it" and for an hour they basically stood there and shouted at her to get her to move and said that she was endangering the baby by not doing it and things like that and so I was just I couldn't hear the conversation that was going on	Staff not helping wife [lack of care]
408	I	right	
409 410 411	R	but all I could hear was basically for an hour my wife screaming in the room next to me and I wasn't able to do anything about it	Hearing wife's screams; unable to help [vivid recall; helplessness]
412	I	yes so	
413 414 415 415	R	erm so I you know at that point I didn't know what was going on I didn't know if she was in, you know she was in physical danger, if my baby was, erm what was actually happening I didn't have a clue	No clue what was happening or if wife and baby were safe [uncertainty]
416	I	yeah so	
417	R	it wasn't until sorry	
418 419 420	I	sorry no I was going to say was that was going on through your, I was just wondering what was going through your mind when you were there on your own	
421 422 423 424 425 426 427	R	oh erm well yeah all sorts was going through my mind when I was there I hadn't a clue what was happening, it wasn't helped by the fact that I was incredibly uncomfortable because I'd actually put the they had a like a wall of scrubs, this is kind of beside the point but they had a wall of surgical scrubs and they told me to get changed into them	Not knowing what was happening [uncertainty] Physically uncomfortable [cumulative stress]
428	I	yeah	
429	R	and I just grabbed the first pair and put them on	

125 126 127		that and so she was in a bed for this whole process and was really sore and they were just dismissive of everything and	Dismissive of partner's discomfort
128	I	right	
129 130	R	(06.20) so it kind of put more of us put our backs up a bit to start with	"backs up" to start with
131	I	yeah	
132 133 134 135 136 137 138	R	erm that process went on and parts of that were quite traumatic. They lost the initial pesary that was in that they then had to recover and the lost it behind my wife's cervix and it took, they had three midwives all fishing about trying to get it out and you know there was a lot of blood about and erm generally just causing my wife a lot of pain at that point	Staff causing wife's pain
139	I	yeah	
140 141	R	which was, because she was still and the baby was still in there that was quite stressful	Stressful
142	I	yeah	
143 144 145 146 147 148	R	and that process kind of went on for I think the final thing went in like on the Tuesday night so it was you know it was a kind of 48 hour just not much happening apart from occasional, occasionally being patronised and bouts of severe pain for my wife. I had to go home on the Tuesday night	Being patronised [staff responses] Wife in severe pain.
149	I	right	
150 151 152 153 154	R	erm and then come back in first thing on the Wednesday morning. Then when I got in my wife was in, was in a terrible state she was, she was in severe pain but she wasn't she didn't know what it was and they weren't really explaining to her what was going on	Distress at pain Lack of communication
155	I	ok	
156 157 158 159 160 161	R	and they had er (sighs) she wasn't getting what the kind of labour pains that we expected. We'd been told we'd get you know contractions for a couple of minutes and then nothing for a while and then contractions for a couple of minutes she seemed to be the other way round she was getting like 20 minutes of severe pain	Not what they'd expected [expectations] [unprepared]
162	I	right	
163 164 165 166 167	R	and then a couple of minutes off and then 20 minutes of severe pain and a couple of minutes off. And all the staff they just, they just kind of dismissed it they basically didn't believe her that that's what was happening	Dismissed. Felt disbelieved. [staff responses] [lack of care]

Appendix N.
Iteration of the template highlighting changes

1. Experience of birth
    1. Expectations
        i. Birth would not be difficult
        ii. Versus reality
    2. Rollercoaster of events and emotion
        i. Suddenness with which events became distressing
        ii. Influx of people
        iii. Multiplication of stressors
            i. Build up to the birth
            ii. Birth itself
            iii. Short-lived relief
            iv. Partner's health
    3. Changes in perception
        i. "a blur"
        ii. Surreal
        iii. Distorted sense of time
    4. Emotional aspects
        i. Fear of death
        ii. Anxiety
        iii. Distress at partner's pain
        iv. Keeping control of emotions
        v. Helplessness – 'like watching a car go off a cliff'
            i. Inability to act
            ii. Uncertainty about what was happening
        vi. Numb
    5. Isolation/ abandonment
        i. During the birth
        ii. Being excluded/ sent home
    6. Loss of positive/ shared experiences
        i. Enjoyment of the moment of birth
        ii. Baby's "firsts"
        iii. Dividing attention
    7. Staff responses
        i. Dismissive
        ii. Carelessness
        iii. Lack of acknowledgement of couple's difficulties
        iv. Avoidance/ awkwardness
    8. Remembered images and sounds
        i. Blood
        ii. Screams

Note:
After coding the first three interviews, the initial level 2 codes for 'Experience of birth' were found to be redundant, given the codes emerging from the data. 'Emotional aspects' was retained but 'birth events', 'thought processes' and 'worst aspects' were deleted and replaced with the emergent codes and themes for

2. Post-natal emotional responses
    1. Separateness
        i. Memory loss
        ii. Dazed
        iii. Layers of shock
    2. Anxiety

Example of theme deletion – cross-over with Impact on Self made this code redundant in the final template

3. Impact on self
    1. Preoccupation
        i. "flashbacks"

ii. Rumination
iii. Vivid images and sounds
iv. Triggered memories

2. Work
   i. Concentration difficulties
   ii. Less productive
   iii. Apathy
3. Less emotional control
   i. More emotional
   ii. At 'random'
4. Thoughts of future pregnancies
   i. Reluctance
      1. Uncertainty about ability to cope
5. Desire for resolution

4. Ways of managing responses
   1. Avoidance
      i. 'putting it in a box'
      ii. Not thinking about it
      iii. Not talking about it
      iv. Avoidance of triggers
      v. 'getting on with it'
         1. 'someone's got to be the strong one'
      vi. Hiding emotions
   2. The right to feel affected
      i. 'nothing's happened to *me*'
      ii. 'you're just the man'

Example of code that changed scope in final template – moved to higher order due to the importance attached

5. Relationship with partner
   1. Positive aspects
      i. 'Made our relationship stronger'
         1. Respect as wife and mother
   2. Negative aspects
      i. Lack of support
      ii. Wife's response to trauma
         1. Difficulty of seeing her deal with it

6. Relationship with child
   1. Positive aspects
      i. Good relationships
      ii. Unexpected consequence of being primary carer
         1. More time with baby
         2. More 'hands on' from the start
   2. Negative aspects (exception)
      i. 'Uneasy relationship'
      ii. Lack of tolerance

7. What may have helped and when
   1. Being prepared
      i. 'it's not risk free'
   2. Staff responses
      i. Greater communication

   ii. Acknowledgement of difficulty/ distress
   iii. ‘someone to talk to’ after the birth
3. Timing of delivery and support
   i. Men are overlooked
   ii. Tension between wanting help and being seen to take it
      1. Some support would help
      2. Anonymity

8. Attitudes towards interview
   1. Positive
      i. ‘good opportunity to talk’/ validation
      ii. Anonymity
      iii. Helping other fathers

Data from participants	Code	Subthemes		Theme
		Level 3	Level 2	
"I just thought it's like one of those processes that happens and there'll be no complications" (F5) "There was no sign that anything was wrong, it just felt like a kind of, erm, normal birth… there was no reason for concern" (F6) "then no particular signs of (pause) any problem during the labour" (F9) "and everything seems to be progressing well, erm…[partner] was going through, y'know, the stages, the midwife was thinking that, y'know, it wouldn't be long." (F11)	No concerns initially	Rapid changes in events and environment	Rollercoaster of events and emotion	Experience of birth
"nothing then happened for, god, I don't know, 12 hours or something like that. Or so. And, and, er..and then, then it, it sort of seemed to suddenly, y'know, well decided that, erm, wife or so was getting tired. I think there was a heartbeat issue. And er, and so it was obvious that the that [daughter] was sort of in stress and whatever so they needed to sort of get her, y'know, get her out as quickly as possible" (F4) "they, they quickly rushed her, they said 'we're going to rush for an emergency c-section' and this is where you just think 'oh God'" (F5) "It just descended from being very straightforward to very traumatic very quickly" (F6) "that all happened, I mean that all happened sort of in the space of five, five minutes or so" (F9) "it all seemed to happen very, very quickly, in about twenty, thirty minutes we'd gone from going in to, erm, [daughter] our daughter being born" (F8) "it was like dramatic everything happened, we suddenly then we were in a, in a, two minutes later we were in a delivery room and there's a caesarean going on." (F10) "then, erm, all of a sudden I was told to put some gowns on and that she was going to theatre." (F11)	Suddenness/ rapidness of events			
"it got to one stage where it felt like 30 people in the room or something and there definitely, there weren't that many, but there were a lot of people giving sort of conflicting instructions" (F2) "more and more people started turning up and er into the theatre. There would be more obstetricians coming in and then you know more nurses and there ended up being a lot of people in theatre and nobody was really telling us anything other than they couldn't stop the bleeding" (F3) "And then the midwife, I can't remember if she pulled the panic button or not but people came quickly" (F7) "and in no time at all there were at least ten people in the room" (F9) "it was some dramatic, put the wheels down, we're grabbing bags, upstairs "you're going to the delivery suite" and then about 8 people appeared" (F10) "it was a bit of a blur in the sense that, erm, about half a dozen people came into the room" (F11)	Influx of people			